



**BEHAVIORAL HEALTH**

**INITIAL MENTAL HEALTH OUTPATIENT AND/OR  
CHEMICAL DEPENDENCY PRIOR AUTH REQUEST FORM**

LOB:  QUEST  ACAP  
 Service Type:  MH  CD  Dual DX  
 Auth Request Type:  Standard  Retro

<b>1. Provider/Facility:</b> _____  <b>Contact Person:</b> _____	<input type="checkbox"/> Big Island <input type="checkbox"/> Maui <input type="checkbox"/> Oahu  <input type="checkbox"/> Molokai <input type="checkbox"/> Kauai <input type="checkbox"/> Lanai	<b>Phone:</b> _____	<b>Fax:</b> _____	<b>Request Date:</b> _____
<b>2. Member Name:</b> _____ <b>Member ID:</b> _____ <b>DOB:</b> ____/____/____ <b>Age:</b> _____				
<b>3. DSM/ICD 10 Diagnostic codes:</b>  Primary: _____  Secondary: _____  _____	<b>7. Requested # of Sessions:</b> _____ <b>From:</b> _____ <b>To:</b> _____			
<b>4. Medical Conditions:</b>  _____	<b>8. Required Documentation: Please submit required clinical notes for either 6A or 6B as listed below:</b>  A. <b>Outpatient Mental Health:</b> <input type="checkbox"/> Clinical Summary <input type="checkbox"/> Behavioral Contract (If applicable)  B. <b>Chemical Dependency/Dual Diagnosis:</b> <input type="checkbox"/> UA results <input type="checkbox"/> Behavioral Contract (If applicable); progress notes and relapse prevention plan.			
<b>5. Z Codes: Please check areas of concern ( if applicable)</b>  <input type="checkbox"/> Primary Support Group <input type="checkbox"/> Legal System/Crime <input type="checkbox"/> Housing <input type="checkbox"/> Economic <input type="checkbox"/> Social Environment <input type="checkbox"/> Occupational <input type="checkbox"/> Access to Care <input type="checkbox"/> Educational  <b>Other:</b> _____	<b>9. If this is a Retro-request please explain why:</b> _____ _____			
<b>6. Level of Care Requested:</b> <input type="checkbox"/> Social Detox <input type="checkbox"/> Res <input type="checkbox"/> PHP <input type="checkbox"/> IOP <input type="checkbox"/> LIOP <input type="checkbox"/> OPS <input type="checkbox"/> Methadone Maintenance	<b>10. Does member require an Interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, what language:</b> _____			

Is Care Coordination requested:  Yes  No (If yes, please explain): \_\_\_\_\_

QUEST only: Potential SMI/SPMI/SEBD:  Yes  No

**CLINICAL INFORMATION: (Please complete the following)**

Substance Abuse Treatment History:  Yes  No (If Yes, please complete the grid below)

	Treatment #1	Treatment #2	Treatment #3	Treatment #4
Dates of TX:				
Facility:				
Level of Care:				
Substance:				
Length of TX:				
TX Outcome:				

1. Why is member seeking treatment: \_\_\_\_\_
2. Any CWS (CPS) involvement?  Yes  No (If Yes, please provide name and phone # of CWS (CPS) worker): \_\_\_\_\_
3. Any pending legal charges?  Yes  No (If Yes, please explain): \_\_\_\_\_
4. Probation/Parole officer name and # if applicable: \_\_\_\_\_
5. Recent incarceration?  Yes  No (If yes, date of release): \_\_\_\_\_

**6. Substance Use:**

Drug(s) of Choice:				
Age of Onset:				
Date of Last Use:				
Amount Used:				
How Often Used:				

7. Psychiatric history?  Yes  No (If yes, please provide DX): \_\_\_\_\_
8. Any current psych. symptoms?  Yes  No (If yes, please describe): \_\_\_\_\_
9. Potential safety risk?  Yes  No (If yes, please explain): \_\_\_\_\_

10. Current psychiatric medication?  Yes  No  Unknown (If yes, please fill out box below):

Medication	Dose/Frequency	Start Date	Prescriber/Specialty

Is member adherent with meds?  Yes  No

## ASAM DIMENSIONS (please explain all medium and high ratings)

<b>1. Alcohol Intox. And/or Withdrawal Potential</b> <ul style="list-style-type: none"> <li>Any risk of severe withdrawal/seizures?</li> <li>Any current signs of withdrawal?</li> </ul>	<b>LOW</b>	<b>MED</b>	<b>HIGH</b>
<b>EXPLAIN</b>			

<b>2. Biomedical Conditions &amp; Complications</b> <ul style="list-style-type: none"> <li>Any current physical illness (besides withdrawal) that may impact course of treatment?</li> <li>Is member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>	<b>LOW</b>	<b>MED</b>	<b>HIGH</b>
<b>EXPLAIN</b>			

## ASAM DIMENSIONS (please explain all medium and high ratings)

<b>3. Emotional/ Behavioral or Cognitive Conditions &amp; Complications</b> <ul style="list-style-type: none"> <li>Any psych. illness or psychological, behavioral, or emotional problems that may impact the course of treatment?</li> </ul>	<b>LOW</b>	<b>MED</b>	<b>HIGH</b>
<b>EXPLAIN</b>			

<b>4. Readiness to Change (Treatment Acceptance/Resistance)</b> <ul style="list-style-type: none"> <li>Is the member objecting/resistant to treatment?</li> <li>What is the member's readiness to change?</li> </ul>	<b>LOW</b>	<b>MED</b>	<b>HIGH</b>
<b>EXPLAIN</b>			

## ASAM DIMENSIONS (please explain all medium and high ratings)

<b>5. Relapse (Continued Use Potential)</b> <ul style="list-style-type: none"> <li>Is the member in immediate danger of continued severe distress, and drinking/drug behavior?</li> <li>Does the member have any understanding of, or skills in which to cope with his/her addiction problems in order to prevent relapse/continued use?</li> </ul>	<b>LOW</b>	<b>MED</b>	<b>HIGH</b>
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**EXPLAIN**

<b>6. Recovery Environment</b> <ul style="list-style-type: none"> <li>Are there family members, significant others, living situations, or school/work situations that pose a threat to TX engagement and success?</li> <li>Does the member have supportive friendships, financial, educational, or vocational resources that will increase the likelihood of successful TX?</li> </ul>	<b>LOW</b>	<b>MED</b>	<b>HIGH</b>
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**EXPLAIN**

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**LEVEL OF CARE DETERMINATION: \*\* FOR AC Use Only**

LOC	DATE OF REQUEST	SESSIONS	START DATE	END DATE	TX PLAN DUE DATE	TC DUE DATE	AUTH #	CRITERIA USED
APPROVED: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PARTIAL    DATE OF DECISION:    Reviewers signature _____    MD Signature: _____								