

Ohio Medicaid Authorization Form - Community Behavioral Health

Managed Care Entity Contact Information:

| Member Information | | | |
|---|--|---|---|
| Managed Care Entity (MCE) <input type="checkbox"/> Medicaid Managed Care <input type="checkbox"/> MyCare Ohio <input type="checkbox"/> OhioRISE | | Date of Request (mm/dd/yyyy) | |
| Request Type <input type="checkbox"/> Initial <input type="checkbox"/> Concurrent | | Service Request <input type="checkbox"/> Routine <input type="checkbox"/> Expedited/Urgent** (select expedited for ACT and IHBT) | |
| Member Name | | Date of Birth (mm/dd/yyyy) | |
| Member Phone Number | | Member Medicaid ID# | |
| Provider Information | | | |
| Billing Provider/Agency Name | | Billing Provider/Agency Service Location | |
| Provider/Agency Contact Name | | | |
| Provider NPI | Provider Tax ID Number | Phone Number | Fax Number |
| Medicaid Provider Number | | Provider Status <input type="checkbox"/> MCE Contracted <input type="checkbox"/> MCE Non-contracted | |
| Service Requested | | | |
| | Service Code Requested | Units/Visits Requested | Requested Start Date or Dates of Service |
| Assertive Community Treatment* | <input type="checkbox"/> H0040 | | |
| MRSS Stabilization Service (more than 6 weeks) | <input type="checkbox"/> S9482 | | |
| Psychological/Neuropsychological Testing (> 20 hours per calendar year) | <input type="checkbox"/> 96130 <input type="checkbox"/> 96131 <input type="checkbox"/> 96136 <input type="checkbox"/> 96137 <input type="checkbox"/> 96132 <input type="checkbox"/> 96133 | | |
| SBIRT Services | <input type="checkbox"/> G0396 <input type="checkbox"/> G0397 | | |
| Psychiatric Diagnostic Evaluation | <input type="checkbox"/> 90791 <input type="checkbox"/> 90792 | | |
| Alcohol or Drug Assessment | <input type="checkbox"/> H0001 | | |
| Peer Support (more than four hours on same day) | <input type="checkbox"/> H0038 | | |
| Partial Hospitalization (Medicare only) | <input type="checkbox"/> G0410 <input type="checkbox"/> G0411 | | |
| Other Services/Out-of-network Providers | | | |
| OhioRISE Only Services | | | |
| Behavioral Health Respite* | <input type="checkbox"/> S5150 <input type="checkbox"/> S5151 | | |
| Intensive Home-Based Treatment* | <input type="checkbox"/> H2033 <input type="checkbox"/> H2015 | | |
| Primary Diagnosis (ICD-10) – including provisional diagnosis | | | |

Services marked with an asterisk () may require additional assessment results to be provided (e.g. ANSA, CANS [including CIP-IHBT version], Achenback)

| Instructions for Service Requests |
|--|
| <p>Requests for Substance Use Disorder (SUD) Residential Treatment (H2034 and H2036) and Partial Hospitalization (H0015TG) should be submitted using the ODM 10276 “Substance Use Disorder Services Prior Authorization Request” form.</p> <p>The following information should be submitted to the MCE with this form:</p> <ul style="list-style-type: none"> • Include service start date and referral source along with reason for services • Attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service. • Provide primary/secondary diagnoses and psychosocial issues/barriers to treatment • Provide pertinent medical and BH history including suicidal ideation/homicidal ideation risk • Provide treatment plan with target dates and discharge plan • <i>For continued stay requests please provide:</i> any new problems identified, an update on the treatment plan including how lack of progress is being addressed in any areas, updated discharge plan, and updated information on psychosocial barriers. |