Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Member's Full Name: Medicaid #:

# *Service Authorization Request Form*

## MENTAL HEALTH SKILL-BUILDING (MHSS) H0046 INITIAL

Please note, this communication applies to Anthem HealthKeepers Plus Medicaid products offered by HealthKeepers, Inc. If you have any questions about this communication, call Anthem HealthKeepers Plus Provider Services at **800-901-0020.**

| MEMBER INFORMATION | | PROVIDER INFORMATION | |
|---|---|---|---|
| Member First Name: | | Organization Name: | |
| Member Last Name: | | Group NPI #: | |
| Medicaid #: | | Provider Tax ID #: | |
| Member Date of Birth: | | Provider Phone: | |
| Gender: | ☐ Male ☐ Female ☐ Other | Provider E-Mail: | |
| Member Plan ID #: | | Provider Address: | |
| Member Address: | | City, State, ZIP: | |
| City, State, ZIP: | | Provider Fax: | |
| Parent/Guardian (if applicable): | | Clinical Contact Name & Credentials*: | |
| Parent/Guardian (if applicable) Contact Information: | | Clinical Contact Phone: | |
| | | * *This is the individual to whom the MCO can reach out to answer additional clinical questions.* | |

**Request for Approval of Services:** **Retro Review Request?** ☐ Yes ☐ No

From _____(date), To _____(date), for a total of _____units of service.
Plan to provide _____hours of service per week.

**Is this a new service for the member?** ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)

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| **Primary ICD-10 Diagnosis** | |
| **Secondary Diagnosis** | |

**SECTION I: MENTAL HEALTH SKILL-BUILDING ELIGIBILITY CRITERIA**

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| **Individuals qualifying for Mental Health Skill Building Services (MHSS) must demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities. Services are provided to individuals who require individualized training to achieve or maintain stability and independence in the community.** | ☐ Yes ☐ No |
| **Please describe member's current functional impairments:** | |
| **Please describe why MHSS services are required for member to achieve or maintain stability and independence in the community (Ex: recent increase in symptoms/decrease in functioning? Transitioning to an independent living setting? Current risk of homelessness or hospitalization?):** | |

**https://providers.anthem.com/va**


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| **The individual shall have one of the following as a primary diagnosis:**<br>**1. Schizophrenia or other psychotic disorder as set out in the DSM**<br>**2. Major Depressive Disorder — Recurrent**<br>**3. Bipolar I or Bipolar II**<br>**4. Any other DSM mental health disorder that a physician has documented specific to the identified individual within the past year to include all the following:**<br>**i. that is a serious mental illness;**<br>**ii. that results in severe and recurrent disability;**<br>**iii. that produces functional limitations in the individual's major life activities that are documented in the individual's medical record, and;**<br>**iv. that the individual requires individualized training to achieve or maintain independent living in the community.** | ☐ Yes ☐ No |
| **The individual requires training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.**<br><br>**Please describe member's current skill level and abilities - be specific to track progress or lack of progress: (Provide examples; Identify - frequency, severity, and duration of each behavior)** | ☐ Yes ☐ No |
| **Prior to starting MHSS services the individual has been determined to have a prior history of psychiatric hospitalization, residential crisis stabilization, ICT or Program of Assertive Community Treatment (PACT) services, placement in a psychiatric residential treatment facility, or Temporary Detention Order because of decompensation related to serious mental illness.** | ☐Yes ☐No |

| Name of Service | Date of Service | Reason for Admission |
|---|---|---|
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| **Prior to starting MHSS services the individual has a prescription for anti-psychotic, mood stabilizing, or antidepressant medications within 12 months prior to the assessment date unless there is signed documentation from a physician or other licensed prescribing practitioner indicating that medications are contraindicated.** | ☐ Yes ☐ No |

| Name of Medication | Dosage | Frequency |
|---|---|---|
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| ☐ **No psychotropic medications prescribed, documentation of contraindication is attached** | |
| ****If under 21 years old — Member is in an independent living situation or actively transitioning into an independent living situation (not living with a parent or guardian or in a supervised setting and providing own financial support).** | ☐ Yes ☐ No<br>☐ NA |

| **SECTION II: CARE COORDINATION** |
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| **Primary Care Physician:** |
| **Other medical/behavioral health concerns (including substance abuse issues, personality disorders, dementia, cognitive impairments) that could impact services?** ☐ Yes ☐ No (If yes, explain below.) |

| **Please indicate other medical/behavioral services and additional community supports/interventions received:** | | |
|---|---|---|
| Name of service/treatment | Provider/Contact Information | Frequency |
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**Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:**

**Does the member currently have any services in place to assist with daily living skills, social skills, socialization, medication management, and money management? (Ex: Assisted living or group home staff, Psychosocial Rehabilitation, payee services, supportive friends or family). Please list any current services being provided to this member as described above:**

**If services are in place for this member, please clarify how additional Mental Health Skill-Building Services are necessary and will not duplicate the services member is currently receiving:**

## SECTION III: TRAUMA-INFORMED CARE

**Trauma-Informed Care** (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)

**Is there evidence to suggest this member has experienced trauma?** ☐ Yes ☐ No

**What is your plan to assess/refer and address the current and potential effects of that trauma?**

## SECTION IV: INDIVIDUAL TREATMENT GOALS

**Treatment Goals/Progress:**

- Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions or referral in the treatment plan.
- Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential.
- Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress.
- Include any appointments and medications adherence issues and plans to address this, if applicable.

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| **Resources and Strengths:** Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports. |
| **Please describe any barriers to treatment:** |
| **Goal/Objective** (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if [80%], state [8 of 10] as a more trackable value): |
| **Please describe where the member is now regarding this specific objective.** |
| **How many days per week will be spent addressing this goal on average?** |
| **What specific training and interventions will be provided to address this goal?** |
| **How will you measure progress on the training or interventions provided?** |
| **Goal/Objective** (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if [80%,] state [8 of 10] as a more trackable value): |
| **Please describe where the member is now regarding this specific objective.** |
| **How many days per week will be spent addressing this goal on average?** |

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| **What specific training and interventions will be provided to address this goal?** |
| **How will you measure progress on the training or interventions provided?** |
| **Goal/Objective** (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if [80%], state [8 of 10] as a more trackable value): |
| **Please describe where the member is now regarding this specific objective.** |
| **How many days per week will be spent addressing this goal on average?** |
| **What specific training and interventions will be provided to address this goal?** |
| **How will you measure progress on the training or interventions provided?** |

| **SECTION V: DISCHARGE PLANNING** |
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| **DISCHARGE PLAN** (Identify lower levels of care, natural supports, warm-hand off, care coordination needs) | | |
|---|---|---|
| Step Down Service/Supports | Identified Provider/Supports | Plan to assist in transition |
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| Recommended level of care at discharge: | | |
| Estimated date of discharge: | | |

*The appropriate assessment or addendum has been completed by an LMHP, LMHP-R, LMHP-S, or LMHP-RP and the individual's psychiatric history information reviewed. By my signature (below) I am attesting that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this* .

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed name of LMHP (Or R/S/RP): _____

Credentials: _____

Date: _____

If any additional CMHRS services were recommended by the assessment or addendum referenced above, please identify the services here:

| **NOTES SECTION** |
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| **If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.** |