Texas Children's® Health Plan
The best decision a family can make.

Behavioral Health Prior Authorization Form

Phone Number	832-828-1004 Option #5
Toll Free Phone Number	1-877-213-5508
STAR	1-866-959-2555
CHIP	1-866-959-6555
STAR Kids	1-800-659-5764
Fax Number	832-825-8767
Toll Free Fax Number	1-844-291-7505

Member Information

Plan: ☐ CHIP ☐ Star ☐ Star Kids Date of Request:_____ Admit Date: _____

Request Type: ☐ Initial ☐ Concurrent

Member Name: _____ DOB:_____

Member ID#: _____ Member Phone: ( ) -

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

*Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/ non-urgent.

Provider Information

Treatment Provider/Facility/Clinic Name and Address: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Attending Psychiatrist Name: _____

UR Contact Name: _____UR Phone#/Fax#:_____

Facility Status: ☐ PAR ☐ Non-PAR Member Court Ordered? ☐ Yes ☐ No ☐ In Process Court Date: _____

Service Type Requested

Service is for: ☐ Mental Health ☐ Substance Use

☐ Inpatient Psychiatric Hospitalization ☐ Involuntary ☐ Voluntary ☐ Subacute Detoxification ☐ Involuntary ☐ Voluntary	☐ Residential Treatment ☐ Partial Hospitalization Program ☐ IOP _____ ☐ Electroconvulsive Therapy (ECT) ☐ Non-PAR Outpatient Services ☐ Other – Describe: _____ _____	☐ Electroconvulsive Therapy (ECT) ☐ Psychological/Neuropsychological Testing ☐ Non-PAR Outpatient Services ☐ Other – Describe: _____ **List Psychological/Neurological Test/ Hours Requested:** _____ _____

Procedure Code(s) and Description Requested: _____, _____, _____, _____ Days requested (inpatient): _____

Dates of Service Requested _____ through _____ Outpatient Sessions Requested (limit 8 per request): _____

ICD10 Primary Diagnosis Code for Treatment (including Provisional Diagnosis)	
Additional Diagnoses (including any known Medical Diagnoses/Conditions)	
Psychosocial Barriers (formerly Axis IV)	
Drug Testing (date completed/results)	Date completed _____ ☐ Positive ☐Negative

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Clinical Information

Please provide the following information with the request for review:

Neuropsychological/Psychological Testing: (as covered per benefit package)

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of symptoms and impairment
- Member and Family psych /medical history
- Documentation that medications/substance use have been ruled out as contributing factor
- Test to be administered and # of hours requested, over how many visits and any past psych testing results
- What question will testing answer and what action will be taken/How will treatment plan be affected by results

Electroconvulsive Therapy (ECT): (as covered per benefit package)

Acute/Short-Term:

- Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.)
- ECT indications (acute symptoms refractory to medication or medication contraindication)
- Informed consent from patient/guardian (needed for both Acute and Continuation)
- Personal and family medical history (update needed for Continuation)
- Personal and family psychiatric history (update needed for Continuation)
- Medication review (update needed for Continuation)
- Review of systems and Baseline BP (update needed for Continuation)
- Evaluation by anesthesia provider (update needed for Continuation)
- Evaluation by ECT-privileged psychiatrist (update within last month needed for Continuation)
- Any additional workups completed due to potential medical complications

Continuation/Maintenance:

- Information updates as indicated above
- Documentation of positive response to acute/short-term ECT
- Indications for continuation/maintenance

Non-PAR Outpatient Services Initial:

- Rationale for utilizing Out of Network provider
- Known or Provisional Diagnosis

Concurrent/Ongoing:

- Rationale for utilizing Out of Network provider
- Personal and family psychiatric medical history (comprehensive assessment/ History and Physical are acceptable)
- Medication review
- Known barriers to treatment and other psychosocial needs identified
- Treatment plan including ELOS and discharge plan
- Additional supports needed to implement discharge plan

Inpatient Services:

- Initial intake assessment/notes
- Labs
- Pregnancy test (if applicable)
- UDS results
- Psychosocial assessment (by 4th day of inpatient stay)
- Preliminary aftercare plans (by 4th day of inpatient stay)
- Final aftercare plans prior to discharge from inpatient stay

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Clinical Review - Initial and Concurrent

"Functioning": Presenting/Current Symptoms that Necessitate Treatment (or Continued Treatment)
* Denotes Documentation of Safety Plan Completed under Additional Information

- ☐ *Suicidal ideations/plan/attempt
- ☐ *Homicidal ideations/plan/attempt
- ☐ *History of Suicidal/Homicidal actions
- ☐ Hallucinations/Delusions/Paranoia
- ☐ Self-Mutilation (ex. cutting/burning self)
- ☐ Mood Lability
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Appetite Changes
- ☐ Significant Weight Gain/Loss
- ☐ Panic Attacks
- ☐ Poor Motivation
- ☐ Cognitive Deficits
- ☐ Somatic Complaints
- ☐ Anger Outbursts/Aggressiveness
- ☐ Inattention
- ☐ Impulsivity
- ☐ Legal Issues
- ☐ Problems with Performing ADL's
- ☐ Poor Treatment Compliance
- ☐ Social Support Problems
- ☐ Learning/School/Work Issues
- ☐ Substance Use Interfering with Functioning

(Medication Administration Document can be submitted in lieu of completing the below.)

Medication Name	Dosage/ Frequency	New from Admit?	Date Current Dose Initiated	Compliant?	Lab/Plasma Level?
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	
		☐ New		☐ Yes ☐ No	

Additional Information (explanation of any checked symptoms or other pertinent information):

- For Inpatient, RTC, and Partial Hospitalization/Day Treatment - Please submit current (within the last 48 hours) Medical Progress Notes for Clinical Review
- For ECT, Psychological/Neuropsych Testing-Applied Behavior Analysis, and non-Par OP Requests – see page 3 for additional information required for review

Aftercare Plan/Follow-up Appointment

Expected Discharge Date: _____ Follow-Up Appointment Scheduled: ☐ Yes ☐ No
(Complete if member is in Inpatient Hospitalization)

*NOTE: First follow-up apt must be scheduled within 7 (seven) days of discharge. Day of discharge counts as day 1. Second follow-up appointment must be scheduled within 30 (thirty) days of discharge. Day of discharge counts as day 1.

Provider Type	Provider Name	Telephone Number	Date of Appointment	Time of Appointment

Is treatment being coordinated with the Psychiatrist or Behavioral Health Practitioner? ☐ Yes ☐ No

If Yes, Name of Provider: _____ Post discharge appointment date: _____

If No, please explain: _____

NOTE: Level of Care coverage is subject to State Contract Specific Covered Services. Please refer to the State Specific Provider Handbook for a list of covered levels of care. Authorization of services does not guarantee payment. Payments for services are pending eligibility at the time of service and benefit coverage.