AlohaCare
For a healthy Hawaii.

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

1. Provider/Facility:_____ **Contact Person:**_____	☐ Big Island ☐ Maui ☐ Oahu ☐ Molokai ☐ Kauai ☐ Lanai	**Phone:**	**Fax:**	**Request Date:**

2. Member Name:_____ **Member ID:**_____ **DOB:**____/____/_____ **Age:**_____

3. DSM/ICD 10 Diagnostic codes:

Primary:_____

Secondary:_____

_____

4. Medical Conditions:

_____

5. Z Codes: Please check areas of concern (if applicable)

☐ Primary Support Group ☐ Legal System/Crime ☐ Housing ☐ Economic
☐ Social Environment ☐ Occupational ☐ Access to Care ☐ Educational

Other:_____

6. Level of Care Requested:

☐ Social Detox ☐ Res ☐ PHP ☐ IOP ☐ LIOP ☐ OPS ☐ Methadone Maintenance

7. Requested # of Sessions:_____

From:_____ **To:**_____

8. Required Documentation: Please submit required clinical notes for either 6A or 6B as listed below:

A. **Outpatient Mental Health:** ☐ Clinical Summary ☐ Behavioral Contract (If applicable)

B. **Chemical Dependency/Dual Diagnosis:** ☐ UA results ☐ Behavioral Contract (If applicable); progress notes and relapse prevention plan.

9. If this is a Retro-request please explain why: _____

_____

10. Does member require an Interpreter? ☐ Yes ☐ No
If yes, what language:_____

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)

1. Alcohol Intox. And/or Withdrawal Potential • Any risk of severe withdrawal/seizures? • Any current signs of withdrawal?	LOW	MED	HIGH
EXPLAIN			

2. Biomedical Conditions & Complications • Any current physical illness (besides withdrawal) that may impact course of treatment? • Is member pregnant? ☐ Yes ☐ No	LOW	MED	HIGH
EXPLAIN			

ASAM DIMENSIONS (please explain all medium and high ratings)

3. Emotional/ Behavioral or Cognitive Conditions & Complications • Any psych. Illness or psychological, behavioral, or emotional problems that may impact the course of treatment?	**LOW**	**MED**	**HIGH**
EXPLAIN			

4. Readiness to Change (Treatment Acceptance/Resistance) • Is the member objecting/resistant to treatment? • What is the member's readiness to change?	**LOW**	**MED**	**HIGH**
EXPLAIN			

ASAM DIMENSIONS (please explain all medium and high ratings)

5. Relapse (Continued Use Potential)	LOW	MED	HIGH
• Is the member in immediate danger of continued severe distress, and drinking/drug behavior? • 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?			

EXPLAIN

sdasD

6. Recovery Environment	LOW	MED	HIGH
• Are there family members, significant others, living situations, or school/work situations that pose a threat to TX engagement and success? • Does the member have supportive friendships, financial, educational, or vocational resources that will increase the likelihood of successful TX?			

EXPLAIN

SDFASDF

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: ☐ YES ☐ NO ☐ PARTIAL DATE OF DECISION: Reviewers signature_____ MD Signature:_____