Mercy Care Substance Use Residential Prior Authorization Request

Fax: **855-825-3165** Telephone: **602-263-3000** TTY **711**

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Instructions for Submitting Substance Use Residential Prior Authorization Requests

A determination will be communicated to the requesting provider.

Form Use: Use this form to request prior authorization for Substance Use Residential Treatment for members with a primary substance use diagnosis. This form can be used for members who have co-occurring issues where the substance use disorder is the primary focus of treatment. If member has SMI designation, this application must be submitted by the member's SMI team. To ensure timely processing of your request and avoid delays, complete this form in its entirety and submit all clinical documentation as requested.

Please review the plan's website www.MercyCareAZ.org for an electronic version of this form. For complete information related to medical necessity criteria and requirements for this level of care, please refer to AHCCCS Medical Policy Manual Section 320-V

Do not use this form to: 1) request an appeal: 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; 7) request a referral to an out of network physician, facility or other health care provider; or 8) request a Single Case Agreement for a non-contracted facility (non-par)

General Form Instructions

- Print with black ink only or type in all capital letters.
- To select/fill an oval, double-click the oval, select "Shape Fill" option and select black as the fill-color to mark your selection.
- Sections 1 through 5 – Complete these sections in their entirety.
- Sections 6 through 9 – Select and complete the section which corresponds to the service authorization being requested.
- Section 10 – Attestation required for all prior authorization requests, complete section in its entirety.

DATE OF REQUEST (MMDDYYYY): _____

CURRENT STATUS:

☐ACC Title 19

☐Non Title 19

☐SMI Title 19

☐SMI Non Title 19

SECTION 1 – MEMBER INFORMATION

1. FIRST NAME _____ 2. LAST NAME _____ 3. MI _____

4. MEDICAID ID# _____ 5. DATE OF BIRTH (MMDDYYYY) _____ 6.MEMBER PHONE NUMBER (xxx-xx-xxxx) _____

7. MEMBER's PCP _____ 8. PCP PHONE NUMBER (xxx-xx-xxxx) _____

9. SMI CLINIC NAME _____ CASE MANAGER'S NAME/ PHONE NUMBER _____

10. DOES THE MEMBER HAVE OTHER INSURANCE: ☐YES ☐NO

11. OTHER INSURANCE NAME: _____

SECTION 2 – REQUESTING / SERVICING PROVIDER INFORMATION

12. REQUESTING PROVIDER FIRST NAME _____ 13. REQUESTING PROVIDER LAST NAME _____

14. CONTACT PERSON (Contact Person for additional questions.) _____ 15. SERVICING PROVIDER NAME/FACILITY/AGENCY _____

16. PHONE NUMBER (xxx-xx-xxxx) _____ 17. FAX NUMBER (xxx-xx-xxxx) _____

Notes: This form must be completed in its entirely in order to receive a determination. Incomplete forms may lead to delays in processing or lack of authorization. AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVICE. TO ENSURE PROPER PAYMENT FOR SERVICES RENDERED PROVIDER/FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.

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18. TIN _____

19. NPI _____

20. IS THE SERVICING PROVIDER A PAR PROVIDER? ☐Yes ☐ No

SECTION 3 – DIAGNOSIS CODES AND SERVICE/HCPCS CODES

21. ICD 10/DSM-5 CODE(s)
_____
_____
_____
_____
_____

22. CODE DESCRIPTION(s)
_____
_____
_____
_____
_____

23. REQUESTED DATES OF SERVICE
Start Date (MMDDYYYY)
_____
End Date (MMDDYYYY)
_____

24. *CPT/HCPCS/REV CODES(s)
_____
_____
_____
_____
_____
_____

25. CODE DESCRIPTION(s)
_____
_____
_____
_____
_____
_____

26. NUMBER OF UNITS or VISITS/FREQUENCY
_____
_____
_____
_____
_____
_____

*Note: If you are unsure of the service code(s), include a description of the service in the "Code Description(s)" field.

SECTION 4 – MEDICATION HISTORY

27.PSYCHIATRIC MEDICATION HISTORY (Attach additional medication history, if needed.)

Medication	Dose Achieved	Duration	Results	Adverse Effects	Reason Discontinued

28.NON-PSYCHIATRIC MEDICATION HISTORY (Please include MAT medications and attach additional medication history, if needed.)

Medication	Dose Achieved	Duration	Results	Adverse Effects	Reason Discontinued

SECTION 5 – PHYSICAL HEALTH HISTORY

29. Known Medical Conditions: _____

30. Known Medication Allergies: _____

31. Pregnancy Status: _____

SECTION 6 – CURRENT LEVEL OF FUNCTIONING

32. Is the m ember able to complete ADLs/ILs independently: ☐Yes ☐No

33. Does the member have the ability to self-administer medications? ☐Yes ☐No

34. If the member is SMI and not able to complete ADLs or self-administer medication the member may require a higher level of care. Please contact the clinical team to have the SMI CM submit the Prior Authorization Request for Adult Behavioral Health Residential Facility Services (Short Term BHRF – H0018) and Adult Behavioral Health Therapeutic Homes application and follow the BHRF PA process. (Link to BHRF application)

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SECTION 7 – REQUIRED DOCUMENTATION

35. Attach the following documents: absence of these documents will delay decision of this request. (check each box of documentation provided)
- ☐ Admit date/time
- ☐ Psychiatric evaluation dated within past year
- ☐ Last 3 psychiatric progress notes from outpatient psychiatric provider & psychiatric notes from Inpatient Hospital
- ☐ ISP/ assessment
- ☐ Staffing note that specifically discusses BHRF
- ☐ ASAM
- ☐Substance use history including which substances used, when they first started using, last use date, amount typically used
- ☐ Legal history/DCS involvement

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