Instructions for Submitting Behavioral Health Prior Authorization Requests

Requests for prior authorization of Behavioral Health services may be requested by Web Portal, telephone, fax or mail based on the urgency of the requested service.

Telephone:	**(800) 357-0146 Prompt 3, 1, 1, 3**	**Mail:**	**Molina Healthcare of Ohio *Attention:* Behavioral Health**
Fax:	**(866) 553-9262**		**P.O. Box 349020**
Web Portal:	**www.MolinaHealthcare.com**		**Columbus, OH 43234-9020**

Providers are encouraged to use the Molina Healthcare of Ohio Prior Authorization Form below. This form can be obtained on the Molina Healthcare website. If you intend to use a different form, you are required to supply the following information, as applicable.

• Member demographic information (name, DOB, social security #) • Provider information (Referring Physician and Referred to Specialist) • Requested service/procedure (including specific CPT/HCPCS Codes) • Member diagnosis (ICD-9 or DSM IV Code and description)	• Clinical indications necessitating service or referral • Pertinent medical history (incl. treatment, diagnostic tests, examination data) • Requested number of visits and frequency of visits over what duration

Molina Healthcare of Ohio will process any "non-urgent" request as quickly as possible but no later than 14 days after receipt of a request. "Urgent" requests will be processed as soon as possible within 72 hours of receipt.

Upon receipt of the request, the requesting practitioner will receive an authorization number. The number may be communicated by phone or fax. **Please include this authorization number on your claim.** If a request must be denied, the requestor will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the practitioner by telephone if at all possible or by fax with confirmation of receipt if telephonic communication fails. Verbal and fax denials are given within one business day of the denial decision, or sooner if required by the member's health condition. The denial letter is mailed at the time the denial is issued.

RECONSIDERATIONS OF A DENIED PRE-SERVICE REQUEST (Additional clinical information must be submitted for consideration)
Within seven days of the determination date, providers may call 1-800-357-0146 to request reconsideration or providers may submit the reconsideration request form, postmarked within the required seven days, by writing to: Molina Healthcare of Ohio Attn: Health Care Services/ Behavioral Health, P.O. Box 349020, Columbus, OH 43234-9020. Reconsiderations are available for services not yet provided. **It is Molina Healthcare's policy not to conduct retrospective authorizations.**

APPEALS
Providers may appeal on behalf of a member. Details regarding the appeals process can be found in the Molina Provider Manual or at www.MolinaHealthcare.com under the Provider section.

EXTENSIONS OF AUTHORIZATIONS
Once a referral has been previously *approved*, the practitioner may call Molina Healthcare of Ohio directly to request an extension of services and provide the required information, or you can complete all sections of this form and fax it to Molina Healthcare at the number provided above.

Services Requiring Prior Authorization	Services Not Requiring Prior Authorization
• Inpatient detoxification and Medication Assisted Treatment for Chemical Dependency • Inpatient psychiatric admission for Mental Health • Outpatient Chemical Dependency Services • Outpatient Mental Health services exceeding 12 visits for members 21 and older and 20 visits for members 0-20 years of age within a calendar year require submission of an updated Care Plan to avoid any delays in approved sessions • Psychological or Neuropsychological Testing • ECT (electro-convulsive therapy) • Services provided by a non-participating provider	• Initial Mental Health assessment (CPT Code 90791/90792) by a participating provider • Medication management (CPT Code 90863) by participating provider • Psychiatry services in a private or public free-standing Psychiatric Hospital are covered when billed independently of hospital • Non-covered services (Please contact Behavioral Health staff for information on non-covered services such as, but not limited to, residential treatment, partial hospitalization, and intensive outpatient programs.)
	Limitations
	• Services provided by Community Mental Health Centers and ODADAS contracted facilities are not covered pursuant to ORC Section 5111.16. • Inpatient psychiatric care in a private or public free-standing Psychiatric Hospital

Prior Authorization Guidelines
- Please **complete all fields on the form with ALL requests for authorization**
- Submit the completed form prior to providing any outpatient Chemical Dependency services, or prior to the 13th Mental Health visit for adults and the 21st Mental Health visit for children before providing services to avoid any delays in obtaining an approved request.
- Authorizations of additional services will be done on a calendar year basis.

MOLINA HEALTHCARE

Service Request Form (for Behavioral Health Prior Authorization)

*Please attach any additional information necessary to ensure timely processing of your request.

Health Care Services
Phone number: 1-800-642-4168
Medicaid fax number: 1-866-449-6843
Medicare fax number: 1-877-708-2116

Plan:
☐ Molina Healthcare (Ohio Medicaid)
☐ Molina Medicare
☐ Other: _____

Section 1	**Member Information**	
Member Name: (Last, First, MI)	Date of Birth: / /	Member I.D:
Address: (No., Street, City, State, Zip)		Phone Number: ( )
Service is: ☐ Initial Request or ☐ Updated Request ☐ Medically Emergent (Needed within 72 hours)	Is there another Insurance Carrier for this service? ☐ Y ☐ N If yes, Name of Company _____	

Section 2	**Provider Information**	
Provider rendering services (Include Degree):	Phone Number: ( )	Fax Number: ( )
Agency:	Address: (No., Street, City, State, Zip)	

Provider/Supervising Signature (Include Degree): _____

Section 3	**Care Coordination Contacts**
Is treatment being coordinated with a PCP? ☐ Yes ☐ No If yes; Name: _____	Is treatment being coordinated with a psychiatrist? ☐ Yes ☐ No If yes; Name: _____

Section 4	**DSM-IV Diagnostic Codes**
Axis I (Include All):	**Axis II:**
Axis III:	**Axis IV**:

GAF: Current: _____ Highest In Past 12 months: _____

Section 5 **Medication**

Is Member on current psychiatric and/or medical medications? If yes, please complete below. Use separate sheet if more space is needed.

MEDICATION	DOSAGE	RESPONSE	MEDICATION	DOSAGE	RESPONSE

Section 6 **Symptom List (Check All That Apply)**

a.	**Psychosis:**	☐ Hallucinations	☐ Delusions	☐ Loose Associations	☐ Dissociation	☐ Inappropriate Affect
b.	**Mood:**	☐ Depressed Mood	☐ Hypomania	☐ Mania	☐ Sleep Disturbance	☐ Concentration
		☐ Weight Loss/Gain	☐ Loss of Motivation / Pleasure		☐ Worthlessness / Guilt	
c.	**Anxiety:**	☐ Panic Attacks	☐ Chronic Worrying	☐ Obsessive Thoughts	☐ Compulsive Behaviors	
		☐ Hyper Vigilance	☐ Phobia			
d.	**Cognitive:**	☐ Dementia	☐ Delirium	☐ Distractible		
e.	**Somatic:**	☐ G. I.	☐ Pain	☐ Conversion / Pseudoneurologic		
f.	**Development Disorders:**		☐ Autism	☐ Aspergers	☐ Mental Retardation	☐ Other Learning Problems
g.	**Disruptive Behavior:**		☐ Oppositional/Conduct	☐ Impulsivity	☐ Hyperactivity	☐ Aggressive ☐ Attention
h.	**Substance:**		☐ Abuse	☐ Dependence	(Specify Type) _____	

i. Learning/School/Work Problems: _____

j. Other Symptoms (Specify) _____

k. Suicidal Ideation: ☐ Yes ☐ No **Homicidal Ideation:** ☐ Yes ☐ No **Other Self Harm:** ☐ Yes ☐ No

Section 7	**Treatment Type / Modality / Goals (Check All That Apply)**		
Type:	☐ Individual	☐ Family	☐ Group
Modality:	☐ Cognitive Behavioral ☐ Chemical Dependency	☐ Interpersonal (Including Family Systems Therapy) ☐ Support / Educational	☐ Other (Specify):
Goals:	☐ Behavior / Cognitive Change ☐ Environmental / Relationship Change	☐ Mood / Affect Change ☐ Supportive Treatment (Maintain Current Functioning)	☐ Insight Into Problems ☐ Other (Specify):
Progress:	☐ Improved	☐ Unchanged	☐ Regressed

Section 8	**Service Request**			
Requested Dates of Service:				CPT Code(s):

Section 9	**MHO Authorization**	
Authorization #:	Approved # of Visits:	Dates of Service:

This is not a guarantee of benefits, only a review of the requested services for appropriateness and necessity. Reimbursement is based on the benefits available at the time of the service.

Signature : _____ Title: _____