Residential Treatment Behavioral Health Authorization Request Form

Humana
Healthy Horizons™ in South Carolina

Healthy Connections

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

Place of Service	☐ Residential Substance Abuse Treatment Facility ☐ Psychiatric Residential Treatment Center

Member Information		
Last Name	First Name	Date of Birth
Phone Number	Humana ID#	Gender ☐ Male ☐ Female
Other Ins. ☐ Yes ☐ No	If yes, please attach a copy of the insurance card or provide the name and contact information of the insurer.	Language Spoken

Treating Provider/Practitioner Information		
Last Name	First Name	NPI
Humana ID#	Participating ☐ Yes ☐ No	Discipline/ Specialty
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Facility/Agency Information		
Name	Facility ID	NPI
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Service type Requested	List REV/HCPCS Code(s)		
Residential: ☐ Mental Health ☐ Substance Abuse			
Service Request Start Date	Projected Length of Stay	Transition of Care ☐ Yes ☐ No	Continuation of Care ☐ Yes ☐ No

Diagnosis - Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	
Are services requested court ordered? ☐ Yes ☐ No If **yes**, please submit a copy of the court order and all supporting documentation.	

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

SCHL9WBEN0721

Residential Treatment Behavioral Health Authorization Request Form

Initial Review Requests

Presenting problem to be addressed by treatment plan:

Date problem began	Duration	Is member under the care of a psychiatrist	☐ Yes ☐ No

Is member currently inpatient ☐ Yes ☐ No	If **yes**, what facility is member admitted and what is the current length of stay?

Does the member have any chronic illnesses that require staff supervision? ☐ **Yes** ☐ **No**
If **yes**, indicate the illness, the severity and how staff time and resources are utilized.

Has the member experienced any acute illnesses, medical complications or medical hospitalizations during the last three months?

Does the member have a current Substance Use Disorder? ☐ **Yes** ☐ **No** If **yes**, please list substance(s) used:

Substances Used in the Past Year	Frequency of Use	Amount Used	Last Use

Has the member exhausted all lower levels of care? ☐ **Yes** ☐ **No**

Please explain why the member cannot be managed safely in a less intensive level of care:

Current/Previous Treatment

Is member currently receiving Outpatient services? ☐ **Yes** ☐ **No**

If **Yes**:

Name of Provider /Facility	Dates	Compliant
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Residential Treatment Behavioral Health Authorization Request Form

Current/Previous Treatment

Any Previous Inpatient, Residential/Rehab, PHP or IOP treatment? ☐ **Yes** ☐ **No**

Level of Care	Name of Provider / Facility	Dates	Compliant
Inpatient			☐ Yes ☐ No
Residential			☐ Yes ☐ No
Partial Hospitalization			☐ Yes ☐ No
IOP/PHP			☐ Yes ☐ No
Intensive Community Based Treatment			☐ Yes ☐ No

If treatment / placement was not successful, please explain:

Has the member exhausted all lower levels of care? ☐ **Yes** ☐ **No**

Please explain why the member cannot be managed safely in a less intensive level of care:

Mental Status Exam and Symptoms

Scale: **0** = None; **1** = Mild; **2** = Moderate; **3** = severe; **N/A** = Not assessed

Check the current level of impairment for each category and provide a brief description:

Symptom	Scale	Description
Depressed Mood	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Self-Mutilation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Impaired Attention/Concentration	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Impulsivity/Dangerous Behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Work/School/ADL Problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Delusions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Eating Disorders	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Fire Setting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Obsession/Compulsion	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Illegal Activities	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Substance Abuse/Dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Substance Use Withdrawal	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Cravings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

Residential Treatment Behavioral Health Authorization Request Form

Mental Status Exam and Symptoms		
Symptom	**Scale**	**Description**
Cruelty to animals	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Memory Impairment	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Impaired Judgment	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Lack of Insight	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Generalized Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Sexually Inappropriate/Aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Suicidal/Homicidal: ☐ Ideation ☐ Plan		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Provide details including previous attempts and dates:		
Hallucinations: ☐ Auditory ☐ Visual ☐ Command		☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Provide details including previous examples and dates:		

Support System and Performance
Relationships/Supports (issues/concerns; Is support available/Is support substance free)? Please provide details:
Role performance school/work issues/concerns. Please provide details:
Current living situation? ☐ Homeless ☐ Independent ☐ Family ☐ Foster home ☐ Incarcerated ☐ Other:

Current Medications (Psychotropic and Medical)			
Medication	Dosage	Frequency	Compliant
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
Are there any medication contraindications? If **yes**, please describe:			
Discharge Plan upon Admission:			

Residential Treatment Behavioral Health Authorization Request Form

Attachments for Initial Review Requests		
☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report
☐ Psychiatric Report	☐ Other:	

Continued Stay Reviews

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for partial hospitalization or intensive outpatient services. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Continued symptoms/behaviors:

Scale: **0** = None; **1** = Mild; **2** = Moderate; **3** = severe; **N/A** = Not assessed

Check the current level of impairment for each category and provide a brief description:

Symptom	Scale	Description
Functioning	☐0 ☐1 ☐2 ☐3 ☐N/A	
Complete assignments	☐0 ☐1 ☐2 ☐3 ☐N/A	
Ability to follow instructions	☐0 ☐1 ☐2 ☐3 ☐N/A	
Perform ADLs	☐0 ☐1 ☐2 ☐3 ☐N/A	

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member Cooperative with Treatment? If **no**, Please provider an explanation.
Individual Counseling			☐ Yes ☐ No
Group Counseling			☐ Yes ☐ No
Psychiatric interventions			☐ Yes ☐ No
Family Counseling			☐ Yes ☐ No
Substance Abuse Counseling			☐ Yes ☐ No
Sexual Reactive Treatment			☐ Yes ☐ No
Sexual Offender Treatment			☐ Yes ☐ No
Other services			☐ Yes ☐ No

Has the member's behavior necessitated a significant change in treatment, medication or supervision?

☐ **Yes** ☐ **No** If **yes**, please specify the changes (use a separate sheet if necessary)

Residential Treatment Behavioral Health Authorization Request Form

Current Medications (Psychotropic and Medical)			
Medication	Dosage	Frequency	Compliant
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If **yes**, please describe:			

Method of Intervention	Frequency	Has the use of these methods become more frequent? If so, please explain
Use of Time-out		
Physical management/Restraint (does not include escorts or assists)		
Calls for outside assistance (law enforcement, non-agency staff, etc.)		
Other		
Updates to Discharge Plan		Expected discharge date

Attachments for Continued Stay Review		
☐ Current Treatment Plan	☐ Biopsychosocial Assessment	☐ Court Order
☐ Psychiatric Report	☐ Other:	

Humana Healthy Horizons™ in South Carolina | Healthy Connections