Ohio Medicaid Authorization Form - Community Behavioral Health

Managed Care Entity Contact Information:

Member Information	
Managed Care Entity (MCE) ☐ Medicaid Managed Care ☐ MyCare Ohio ☐ OhioRISE	**Date of Request** *(mm/dd/yyyy)*
Request Type ☐ Initial ☐ Concurrent	**Service Request** ☐ Routine ☐ Expedited/Urgent** *(select expedited for ACT and IHBT)*
Member Name	**Date of Birth** *(mm/dd/yyyy)*
Member Phone Number	**Member Medicaid ID#**

Provider Information			
Billing Provider/Agency Name		**Billing Provider/Agency Service Location**	
Provider/Agency Contact Name			
Provider NPI	**Provider Tax ID Number**	**Phone Number**	**Fax Number**
Medicaid Provider Number		**Provider Status** ☐ MCE Contracted ☐ MCE Non-contracted	

Service Requested			
	Service Code Requested	**Units/Visits Requested**	**Requested Start Date or Dates of Service**
Assertive Community Treatment*	☐H0040		
MRSS Stabilization Service *(more than 6 weeks)*	☐S9482		
Psychological/Neuropsychological Testing *(> 20 hours per calendar year)*	☐96130 ☐96131 ☐96136 ☐96137 ☐96132 ☐96133		
SBIRT Services	☐G0396 ☐G0397		
Psychiatric Diagnostic Evaluation	☐90791 ☐90792		
Alcohol or Drug Assessment	☐H0001		
Peer Support *(more than four hours on same day)*	☐H0038		
Partial Hospitalization *(Medicare only)*	☐G0410 ☐G0411		
Other Services/Out-of-network Providers			
OhioRISE Only Services			
Behavioral Health Respite*	☐S5150 ☐S5151		
Intensive Home-Based Treatment*	☐H2033 ☐H2015		
Primary Diagnosis (ICD-10) – including provisional diagnosis			

*Services marked with an asterisk (*) may require additional assessment results to be provided (e.g. ANSA, CANS [including CIP-IHBT version], Achenback)

Instructions for Service Requests

Requests for Substance Use Disorder (SUD) Residential Treatment (H2034 and H2036) and Partial Hospitalization (H0015TG) should be submitted using the ODM 10276 "Substance Use Disorder Services Prior Authorization Request" form.

The following information should be submitted to the MCE with this form:

- Include service start date and referral source along with reason for services
- Attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service.
- Provide primary/secondary diagnoses and psychosocial issues/barriers to treatment
- Provide pertinent medical and BH history including suicidal ideation/homicidal ideation risk
- Provide treatment plan with target dates and discharge plan
- *For continued stay requests please provide*: any new problems identified, an update on the treatment plan including how lack of progress is being addressed in any areas, updated discharge plan, and updated information on psychosocial barriers.