

Ohio MyCare Authorization Form - Community Behavioral Health Services

Aetna 855.734.9389 (routine) / 855.734.9393 (expedited)
 Buckeye 877.725.7751 / CareSource 937.487.1664
 Molina 866.449.6843 / UHC 855.633.3306

Member Information

Plan: MyCare Medicaid Date of Request: _____

Request Type: Initial Concurrent

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone: _____

Service Is: Routine Expedited/Urgent** (Please mark expedited for ACT, IHBT, or SUD Residential request)

Provider Information

Billing Provider/Agency Name and Service Location: _____

Provider NPI/Provider Tax ID# (number to be submitted with claim): _____

Contact Name: _____ Phone#/Fax#: _____

Provider Status: PAR Non-PAR Member Court Ordered? Yes No

Service Type Requested

Service is for: Mental Health Substance Use

	Service Code(s) requested:	Units requested:	Requested Dates of Service:
Assertive Community Treatment*	H0040		
Intensive Home-Based Treatment*	H2015		
SUD Partial Hospitalization	H0015		
SUD Residential Treatment	H2034 H2036		
Behavioral Health Respite*	S5150 S5151		
Psychological Testing	96101 96111 96116 96118		
SBIRT Services	G0396 G0397		
Psychiatric Diagnostic Evaluation	90791 90792		
Alcohol or Drug Assessment	H0001		
Specialized Recovery Services Program	T1016 H0038 H2023 H2025		
Partial Hospitalization (Medicare only)	G0410 G0411		

Other Services/Out of Network Providers:

Primary Diagnosis (ICD-10)
(including Provisional Diagnosis)

Clinical Symptoms & Social Barriers

- | | | |
|---|---|---|
| <input type="checkbox"/> Suicidal ideations/plan/attempt | <input type="checkbox"/> Appetite Changes | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Homicidal ideations/plan/attempt | <input type="checkbox"/> Significant Weight Gain/Loss | <input type="checkbox"/> Legal Issues |
| <input type="checkbox"/> History of Suicidal/Homicidal actions | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Problems with Performing ADLs |
| <input type="checkbox"/> Hallucinations/Delusions/Paranoia | <input type="checkbox"/> Poor Motivation | <input type="checkbox"/> Poor Treatment Compliance |
| <input type="checkbox"/> Self-Mutilation (ex. cutting/burning self) | <input type="checkbox"/> Cognitive Deficits | <input type="checkbox"/> Social Support Problems |
| <input type="checkbox"/> Mood Lability | <input type="checkbox"/> Somatic Complaints | <input type="checkbox"/> Learning/School/Work Issues |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anger Outbursts/Aggressiveness | <input type="checkbox"/> Substance Use Interfering with Functioning |
| <input type="checkbox"/> Sleep disturbances | <input type="checkbox"/> Inattention | <input type="checkbox"/> Homeless/Housing Instability |

**Providers should attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service. Services marked with an asterisk (*) may require additional assessment results to be provided (e.g. ANSA, CANS [including CIP-IHBT version], Achenbach).