OUTPATIENT BEHAVIORAL HEALTH
Prior Authorization Fax Form **Intensive Outpatient Therapy**

sunshine health

Complete and Fax to:
1-844-208-9113

This is a standard authorization request that may take up to 7 calendar days to process. **If this is an expedited request for MMA, HK, CW or Medicare, please contact us at 1-844-477-8313. For an expedited request for Ambetter members, please call 1-877-687-1169.**

☐ Request for additional units. Existing Authorization _____ Units _____

**** INDICATES REQUIRED FIELD***

MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth * (MMDDYYYY)

REQUESTING PROVIDER INFORMATION Requesting

NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

Fax

SERVICING PROVIDER / FACILITY INFORMATION

☐ ***Same as Requesting Provider***

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

Fax

AUTHORIZATION REQUEST

Primary Procedure Code * (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Start Date *OR* Admission Date * (MMDDYYYY)

Diagnosis Code * (ICD-10)

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Number of sessions requested

Number of sessions completed

Number of days per week attending

Number of hours per day attending

Has a psychiatric evaluation been conducted? ☐ *Yes* ☐ *No*

If no, indicate why:

Suicidal ☐ Homicidal ☐

Past suicidal attempt date(s)

Past homicidal attempt date(s)

Please indicate current safety plans:

Current assaultive/violent behavior including frequency:

Describe member's previous mental health history:

Is member attending AA/NA meetings? ☐ *Yes* ☐ *No*

Current presentation/symptoms:

Impact on current functioning (occupational, academic, social, etc.)

Current psychotropic medications

Prescriber

Medication

Start date

Compliant ☐ *Yes* ☐ No

If yes, ***how often?***

Was a sponsor identified? ☐ *Yes* ☐ No

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Rev. 8 25 2016
FL-PAF-0675

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Member ID/Medicaid ID *

Last Name, First

Date of Birth * (MMDDYYYY)

Substance Use Disorder | **Drug** | **Amount** | **Frequency** | **First use date** (MMDDYYYY) | **Last use date** (MMDDYYYY)

Treatment plan

Indicate what step member is currently on

Member's current level of motivation

Relapse History

Date of last relapse (MMDDYYYY)

Drug and amount used

Resulting consequences

Goal

Goal start date (MMDDYYYY)

Current progress

Date of NEXT family therapy session: (MMDDYYYY)

List date of the MOST RECENT family therapy session:

Indicate any progress made at the last family therapy session if appropriate

Objectively describe how it will be known that the member is ready to discontinue treatment:

How has the treatment plan changed since the last request?

Requested authorization:

☐ **REV 905 (Behavioral Health IOP)**

☐ **REV 906 (SUD IOP) AR**

Additional information:

Doctor signature and date

(MMDDYYYY)

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