sunshine health

BEHAVIORAL HEALTH
Prior Authorization Fax Form *In Lieu of Services*

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, please contact us at 1-844-477-8313.**

☐ 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

Provider Medicaid ID

☐ *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 *

Additional Procedure Code (CPT/HCPCS) (Modifier)

Additional Procedure Code (CPT/HCPCS) (Modifier)

End Date *OR* Discharge Date (MMDDYYYY)

Total Units/Visits/Days

Addional information:

Functional outcomes

In the last 30 days, have you/your child had problems sleeping or feeling sad?	☐ *Yes* (5)	☐ *No* (0)	In the last 30 days, have you/your child had problems with fears and anxiety?	☐ *Yes* (5)	☐ *No* (0)
Do you/your child currently take mental health medicines as prescribed by your doctor?	☐ *Yes* (0)	☐ *No* (5)	In the last 30 days, has alcohol or drug use caused problems for you or your child?	☐ *Yes* (5)	☐ *No* (0)
In the last 30 days, have you/your child gotten in trouble with the law?	☐ *Yes* (5)	☐ *No* (0)	In the last 30 days, have you/your child actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?	☐ *Yes* (0)	☐ *No* (5)
In the last 30 days, have you/your child had trouble getting along with other people including family and people outside the home?	☐ *Yes* (5)	☐ *No* (0)	Do you/your child feel optimistic about the future?	☐ *Yes* (0)	☐ *No* (5)

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.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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MEMBER INFORMATION

Member ID/Medicaid ID *

Last Name, First

Date of Birth * (MMDDYYYY)

Children Only: In the last 30 days, has your child had trouble following rules at home or school? ☐ ***Yes*** (5) ☐ ***No*** (0)

Children Only: In the last 30 days, has your child been placed in state custody (DCF criminal justice)? ☐ ***Yes*** (5) ☐ ***No*** (0)

Adults Only: Are you currently employed or attending school? ☐ ***Yes*** (0) ☐ ***No*** (5)

Adults Only: In the last 30 days, have you been at risk of losing your living situation? ☐ ***Yes*** (5) ☐ No (0)

Therapeutic approach/evidence based treatment used

Level of improvement to date

Level of improvement to date

Minor

Barriers to discharge

Symptoms

If present, select degree to which it impacts daily functioning.

Anxiety/panic attacks	N/A	Decreased energy	N/A	Delusions	N/A		
Depressed mood	N/A	Hallucinations	N/A	Angry outbursts	N/A	Hyperactivity/ inattention	N/A
Irritability/mood instability	N/A	Impulsivity	N/A	Hopelessness	N/A	Other psychotic symptoms	N/A

Functional impairment related Symptoms

If present, check degree to which it impacts daily functioning.

ADLs	N/A	Relationships	N/A	Substance use disorder	N/A
Physical health	N/A	Work/school	N/A	Drug(s) of choice	

Last date of substance use

Risk assessment

Suicidal None

Homicidal None

Safety plan in place? (if plan or intent indicated) ☐ ***Yes*** ☐ ***No***

If prescribed medication, is enrollee compliant? ☐ ***Yes*** ☐ ***No***

Current measurable treatment goals

Current measurable treatment goals

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.)? ☐ ***Yes*** ☐ ***No***

If so, in what way are these services alone inadequate in treating the presenting problem?

Doctor signature and date

Addional information:

(MMDDYYYY)

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