

Ohio Medicaid Authorization Form - Community Behavioral Health

Managed Care Entity Contact Information:

Member Information			
Managed Care Entity (MCE) <input type="checkbox"/> Medicaid Managed Care <input type="checkbox"/> MyCare Ohio <input type="checkbox"/> OhioRISE		Date of Request (mm/dd/yyyy)	
Request Type <input type="checkbox"/> Initial <input type="checkbox"/> Concurrent		Service Request <input type="checkbox"/> Routine <input type="checkbox"/> 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 <input type="checkbox"/> MCE Contracted <input type="checkbox"/> MCE Non-contracted	
Service Requested			
	Service Code Requested	Units/Visits Requested	Requested Start Date or Dates of Service
Assertive Community Treatment*	<input type="checkbox"/> H0040		
MRSS Stabilization Service (more than 6 weeks)	<input type="checkbox"/> S9482		
Psychological/Neuropsychological Testing (> 20 hours per calendar year)	<input type="checkbox"/> 96130 <input type="checkbox"/> 96131 <input type="checkbox"/> 96136 <input type="checkbox"/> 96137 <input type="checkbox"/> 96132 <input type="checkbox"/> 96133		
SBIRT Services	<input type="checkbox"/> G0396 <input type="checkbox"/> G0397		
Psychiatric Diagnostic Evaluation	<input type="checkbox"/> 90791 <input type="checkbox"/> 90792		
Alcohol or Drug Assessment	<input type="checkbox"/> H0001		
Peer Support (more than four hours on same day)	<input type="checkbox"/> H0038		
Partial Hospitalization (Medicare only)	<input type="checkbox"/> G0410 <input type="checkbox"/> G0411		
Other Services/Out-of-network Providers			
OhioRISE Only Services			
Behavioral Health Respite*	<input type="checkbox"/> S5150 <input type="checkbox"/> S5151		
Intensive Home-Based Treatment*	<input type="checkbox"/> H2033 <input type="checkbox"/> 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
<p>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.</p> <p>The following information should be submitted to the MCE with this form:</p> <ul style="list-style-type: none"> • 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 • <i>For continued stay requests please provide:</i> 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.