Reset Form

Mental Health & Substance Use Disorder General Services Prior Authorization Form

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request. Review our provider manual criteria references.

For questions, call Mental Health and Substance Use Disorder Services at:
612-676-6533 or 1-833-276-1185

Fax form and any relevant documentation:
612-884-2033 or **1-855-260-9710**

Submit Request: UCare's Secure Email Site
Intake: MHSUDservices@ucare.org

MEMBER INFORMATION

UCare ID _____ PMI _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____

ICD-10 _____ Phone _____

SERVICING FACILITY INFORMATION

Facility _____ NPI Number _____

Practitioner _____ NPI Number _____

Service Location Address _____

City, State, Zip _____

Contact Phone _____ Fax _____

REQUESTER INFORMATION

Request Sent By _____ Phone _____

Fax (if different than above) _____ Total Pages Faxed _____

Email _____

MH&SUD General Services (Continued)

STANDARD OR EXPEDITED REQUEST

Please select and complete one option below (STANDARD REQUEST or EXPEDITED REQUEST).

◯ STANDARD REQUEST

- Medicare and Medical Assistance decision within 10 business days.
- IFP decision within 5 business days.

◯ EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.
- Medicare and Medical Assistance decision within 72 hours.
- IFP decision within 48 hours, including 1 business day.
- Billing and retrospective authorizations are not expedited.

1. Proposed date of service: _____
   - Billing and retrospective authorizations are not expedited.
2. Clinical reason for urgency (unrelated to scheduling issues):

3. Provide a contact name and number available for this request:
   - Due to the expedited processing time, please ensure that the designated contact is readily accessible should further information be required.

SERVICE REQUEST/DATES/PROCEDURE CODES/UNITS

Start Date of Request: _____ **End Date of Request:** _____

Admit Date (if different than Start Date of Request): _____

Please list all necessary code(s) and units associated with your visit.

Service Requested: _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

MH&SUD General Services (Continued)

RECOMMENDED DOCUMENTATION

Confirm service and attach the following documents, if applicable:

☐ **Adult Rehabilitative Mental Health Services (ARMHS)**
- Current Diagnostic Assessment, Functional Assessment, Individual Treatment Plan (ITP), and Progress Notes
- Documentation supporting medical necessity for exceeding standard treatment limitations.

☐ **Children's Therapeutic Services and Supports (CTSS)**
- Diagnostic Assessment, Individualized Treatment Plan and CASII, SDQ or ECSII, mental health service history for last 12 months, rationale for additional service units, discharge plan and expected date of achievement.
- Frequency of requested services (procedure code, hours per day, frequency), including schedule of declining frequency in relation to therapeutic goals.

☐ **CTSS Children's Day Treatment**
- Diagnostic Assessment, Individualized Treatment Plan and CASII, SDQ or ECSII, progress notes from last 4 weeks, rationale for additional service units, discharge plan and expected date of achievement.
- If not included in above information: Documentation of individual/group/family therapy and psychoeducation, documentation of monthly psychiatric/medication evaluation

☐ **Early Intensive Developmental and Behavioral Intervention (EIDBI)**
- Initial request: Comprehensive Multi-Disciplinary Evaluation (CMDE)
- Continued service requests: Individual Treatment Plan (ITP)

☐ **Partial Hospitalization Program (PHP)**
- Diagnostic Assessment, Individualized Treatment Plan, level of care assessment, progress notes from last 6 psychotherapy sessions, discharge plan and expected date of achievement.
- Statement signed by a treating physician that member would require inpatient psychiatric care in the absence of PHP.
- If not included in above information: Documentation of weekly psychiatric/medication evaluation, safety planning, and symptoms and functioning within the last week.

☐ **Substance Use Disorder (SUD) Outpatient Treatment**
- Comprehensive Assessment, Individual Treatment Plan (ITP), Treatment Plan Review (TPR), progress notes, and documentation of daily treatment services.
- Documentation of how treatment services beyond threshold will be utilized.
- Member-specific information supporting medical necessity beyond standard treatment limitations.

☐ **Transcranial Magnetic Stimulation (TMS) / Vagus Nerve Stimulation (VNS)**
- Diagnosis, Past Treatment History, TMS/VNS Screening including recent depression screening inventory score, Medication History, Medical History**,** and Individual Treatment Plan (ITP) which includes number and frequency of Treatment Sessions.

ADDITIONAL INFORMATION

Please include any additional information that may support medical necessity: