



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

- Decision within 5 business days (as of 1/1/2026).

EXPEDITED REQUEST

- Only request an urgent/emergent review if waiting for the standard review time-frame would potentially jeopardize the member's health, life, or ability to regain function.
- Decision within 48 hours, including 1 business day (as of 1/1/2026).
- 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 SDQ, 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 SDQ, 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 psycho-education, 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)

☐ **Mental Health 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.
- If not included in above information: documentation of weekly psychiatric/medication evaluation, safety planning, and symptoms and functioning within the last week.

☐ **Psychotherapy**

- Current Diagnostic Assessment, Clinical Summary, Individual Treatment Plan (ITP), and progress notes from last 5 visits.
- Other elements that may apply, including: current risk factors, emergency interventions, professional consultations, test results, medications, symptoms, treatment response.

☐ **Substance Use Disorder (SUD) Partial Hospitalization Program (PHP)**

- Comprehensive Assessment, Individual Treatment Plan (ITP), Treatment Plan Review (TPR), progress notes from last 2 weeks.

☐ **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: