## **Managed Care Entity Contact Information:**

## Ohio Medicaid Authorization Form - Community Behavioral Health

Member Information						
Managed Care Entity (MCE)			Date of Request (mm/dd/yyyy)			
☐ Medicaid Managed Care ☐ MyCare Ohio ☐ OhioRISE						
Request Type			Service Request			
			□ Routine			
☐ Concurrent			☐ 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 Numl		ber
Medicaid Provider Number			Provider Status			
		☐ MCE Contracted ☐ MCE Non-contracted			d	
Service Requested						
	Service Coo		le Requested			Requested Start Date or Dates of Service
Assertive Community Treatment*		□H0040				
MRSS Stabilization Service (more than 6 weeks)		□S9482				
Psychological/Neuropsychological Testing		□96130 □96131 □96136 □96137				
(> 20 hours per calendar year)		□96132 □96133				
SBIRT Services		□G0396 □G0397				
Psychiatric Diagnostic Evaluation		□90791 □90792				
Alcohol or Drug Assessment		□H0001				
Peer Support (more than four hours on same day)		□H0038				
Partial Hospitalization (Medicare only)		□G0410 □G0411				
Other Services/Out-of-network Providers						
OhioRISE Only Services		T				
Behavioral Health Respite*		□S5150 □S5151				
Intensive Home-Based Treatment*			□H2033 □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**

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.

## The following information should be submitted to the MCE with this form:

- 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
- For continued stay requests please provide: 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.