Buckeye Health Plan Behavioral Health Prior Authorization Request Form

Peer Support • TBS • PSR • CPST • Intensive Outpatient (ASAM Level 2)

SECTION 1: PROVIDER INFORMATION

Request Type: ☐ Initial Authorization ☐ Continued Stay ☐ Retrospective

Provider/Agency Name: _____
Rendering Practitioner Name & Credentials: _____
NPI: _____ **Tax ID:** _____
Phone: _____ **Fax:** _____
Contact Person: _____

SECTION 2: MEMBER INFORMATION

Member Name: _____
Medicaid ID: _____
Date of Birth: _____ **Phone:** _____
Address: _____
Primary Diagnosis (DSM/ICD code): _____
Secondary Diagnoses: _____

SECTION 3: SERVICE REQUESTED

Start Date of Authorization: _____ **End Date of Authorization:** _____

Select all that apply and indicate requested units/duration:

Service Type	Code(s)	Requested Units	Frequency	Duration
Peer Support Services	☐H0038 (Ind/Grp)	_____	_____	_____
Therapeutic Behavioral Services (TBS)	☐H2019 ☐H2020	_____	_____	_____
Psychosocial Rehabilitation (PSR)	☐H2017 ☐Other_____	_____	_____	_____
Community Psychiatric Supportive Treatment (CPST)	☐H0036 ☐H0037	_____	_____	_____
Intensive Outpatient Program (IOP – ASAM Level 2)	☐H0015	_____	_____	_____

SECTION 4: CLINICAL INFORMATION

Current Level of Care:

☐ Peer ☐ TBS/PSR ☐ IOP ☐ Other: _____

ASAM Assessment (required for IOP):

Dimension ratings:

1: ___ 2: ___ 3: ___ 4: ___ 5: ___ 6: ___

☐ ASAM Level 2 criteria met (attach assessment)

SECTION 5: FUNCTIONAL & MEDICAL NECESSITY JUSTIFICATION

A. Functional Impairment (check all that apply)

☐ Difficulty with ADLs

☐ Impaired coping or emotional regulation

☐ Impaired community functioning

☐ Safety or crisis risk

☐ Barriers to treatment engagement

☐ Substance use impacting functioning

☐ Legal/family/educational impacts

☐ Other: _____

B. Medical Necessity Rationale (required)

Per **OAC 5160-8-05** and service-specific rules, explain:

- Why the service is necessary to treat the member's behavioral health condition
- Functional deficits/clinical needs addressed
- Why the intensity/frequency requested is needed
- Expected clinical benefit

Clinical narrative (attach documents if needed):

_____

_____

_____

_____

Additional clinical information:

- Why lower-intensity services are insufficient
- Impact on safety, stabilization, or functioning

- Time-limited or ongoing need
- For peer support: explain recovery-oriented purpose and member preference

Narrative:

_____

_____

_____

_____

SECTION 7: TREATMENT PLAN REQUIREMENTS

Attach or include below (required for all services) a current individualized treatment plan (ITP/ISP) that demonstrates:

- Measurable goals linked to requested services
- Progress summary
- Crisis/safety plan (if applicable)
- Coordination with other providers

Key ITP Goals Addressed by Requested Services:

1. _____
2. _____
3. _____

SECTION 8: PROVIDER ATTESTATION

I attest that the information provided is accurate and that the requested services meet the medical necessity criteria outlined in **OAC 5160-8-05**, **Chapter 5160-27**, and Buckeye Health Plan Policy **OH.UM.06**.

Provider Signature: _____
Date: _____

Buckeye will make authorization decisions in accordance with **OAC 5160-26-03.1**, including evidence-based criteria, transparency, and timely review.

Standard prior authorization requests should be submitted for medical necessity review at least five (5) business days before the scheduled service delivery date or as soon as the need for service is identified. It is recommended that prior authorization not be requested more than three (3) weeks prior to the expected start date of the authorization.