Washington Apple Health IMC
Behavioral Health Prior Authorization Form
Phone Number: (877) 542-9231
Fax Number: (844) 747-9828

UnitedHealthcare Community Plan

Washington Apple Health Integrated Managed Care Intake Request Fax Form

Submitted Date Time:	

Member Information:	
Member First Name:	Member Last Name:
Member's DOB:	Member Medicaid/Medicare ID:
Provider Information:	
Provider Facility/Group Name:	Tax ID:
Address 1:	Address 2:
Address City:	Address State:
Address Zip:	Treating Provider:
Additional Info/Phone:	Time and Date of Request:
Ext:	
License level:	Other License level:
Authorization Information:	
Start Date Requested:	Type of Request (Initial, Concurrent)
Requested Services:	Elective/Routine OR Expedited/Urgent:
If Inpatient, Expected Discharge Date:	If Inpatient, Follow-Up Appointment Scheduled? (Note: First follow-up appointment must be within 7 days of discharge)
Procedure Code(s):	Length of Stay Requested:

*Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function.

Requests outside this definition should be submitted as routine/non-urgent.

Clinical Information:	
Current Primary DSM-5 Diagnosis and Code Number:	Current Primary DSM-5 Diagnosis Description:
Secondary DSM-5 Diagnosis Code:	Secondary DSM-5 Diagnosis Description:
Tertiary DSM-5 Diagnosis Code:	Tertiary DSM-5 Diagnosis Description:
Level of Functional Impairment:	Risk of Harm to Self or Others:
Progress Towards Goals:	Other Services Provided by Requesting or Other Entity:
Is Coordination of Care occurring with the above providers?:	Is the member delegated as SMI:
Facility/Provider PAR or Non-PAR:	Member Court Ordered? Date of Order:
Attending Psychiatrist Name (if Inpatient):	UM Contact Name:
UM Contact Phone & Fax:	

Requires Prior Authorization:	**Requires Notification and Concurrent Review:**
☐Residential Treatment	☐Inpatient Hospitalization - Voluntary or Involuntary?:
☐Detoxification (Sub acute, non-hospital setting)	☐Detoxification (Acute setting) – Voluntary or Involuntary?:
☐Crisis stabilization in a residential setting	☐If Involuntary, Court date:
☐Partial Hospitalization Program/Day	☐Risk of Harm to Self or Others:
☐Electroconvulsive Therapy (ECT)	☐WISe Notification:
☐Psychological Testing	☐CLIP Notification:
☐Non-Par Outpatient Services	☐Other (describe):
☐IOP (Intensive Outpatient)	
☐Other (describe):	

Attested and Submitted By: **Email:**

If requesting a service that requires clinical documentation to support request, please provide the appropriate clinical information below with the request for review:

Psychological Testing: *as covered per benefit package

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of presenting symptoms and impairment
- Member and Family psych /medical history
- Documentation that medications/substance use have been ruled out as contributing factor
- Test to be administered and # of hours requested, over how many visits and any past psych testing results
- What question will testing answer and what action will be taken/How will treatment plan be affected by results

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Electroconvulsive Therapy (ECT): *as covered per benefit package

- Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.)
- ECT indications (acute symptoms refractory to medication or medication contraindication)
- Informed consent from patient/guardian (needed for both Acute and Continuation)
- Personal and family medical history (update needed for Continuation)
- Personal and family psychiatric history (update needed for Continuation)
- Medication review (update needed for Continuation)
- Review of systems and Baseline BP (update needed for Continuation)
- Evaluation by anesthesia provider (update needed for Continuation)
- Evaluation by ECT-privileged psychiatrist (update within last month needed for Continuation)
- Any additional workups completed due to potential medical complications
- Continuation/Maintenance: *as covered per benefit package
- Information updates as indicated above
- Documentation of positive response to acute/short-term ECT
- Indications for continuation/maintenance

Non-PAR Outpatient Services: *as covered per benefit package

- Rationale for utilizing Out of Network provider
- Known or Provisional Diagnosis and Current Symptoms
- Any Known Barriers to Treatment
- Plan of Treatment including estimated length of care and discharge plan
- Additional supports needed to implement discharge plan

Inpatient, Detoxification, Residential Treatment, Partial Hospitalization, IOP or Day Treatment: *as covered per benefit package

- CURRENT clinical information to include:
  - Acute Symptoms that warrant treatment or continued treatment at requested level of care
  - Treatment/Interventions being provided to stabilize acute symptoms
  - Include Attending Psychiatrist's Notes; Nursing Notes; and Medication