Medica Behavioral Health: Substance Use Disorder (SUD) Assessment/Fax Cover Sheet

Clear Form

Date:_____ Medica Member # _____

Member Name: _____ DOB: _____

Assessor Name: _____ Contact #: _____

Assess/Update Completed At: _____ Assessment Date:_____

Person Completing This Form: _____ Contact #: _____

ARE YOU MAKING A REQUEST FOR SUD SERVICES? *Use Medication Assisted Treatment request forms for MAT/MMT*

☐ *NO* Please complete the demographic information above and attach the assessment for information purposes only

☐ **YES** You must **attach the most recently completed/updated assessment (e.g. Rule 25/31 or CompAssess) or progress notes**

For this request to be valid, **the information above and below must be completed in full**

SERVICE REQUEST (ONLY COMPLETE THIS SECTION IF YOU ARE REQUESTING COVERAGE OF SERVICES)

Facility/Program Name*:_____Location: _____

*Check this box if no specific facility or program for services has been identified ☐

Which type of service are you requesting? (Complete either the Outpatient or Residential portion, not both)

Acute Hospital Based Inpatient Services (Rehab/Detox) must be called in to 800-848-8327

OUTPATIENT

ENTER REQUEST AS SERVICES WILL BE BILLED, IN HOURLY OR DAILY/PER DIEM UNITS

Hourly/Per Hour Billing Only:	-OR-	Daily/Per Diem Billing Only:
Total # of Treatment Hours being requested, if providing treatment services billed hourly: **Number of Group Hours** _____ **Number of Individual Hours** _____		**Total # of Program Days** being requested, if providing treatment services billed as a per diem: **Number of Days** _____

Track:(Must choose one)	**Program Specifics/Modifiers** (Must check all that apply)
☐ Adolescent ☐ Services Adult Services ☐ Geriatric Services	☐ Co-Occurring Services ☐ Recipients with Children ☐ Special Populations ☐ Medical Services

Dates of Service: Start date for this request:_____ **End date for this request:**_____

Treatment Coordination T1016 U8 HN 15 min per unit **MEDICAID ONLY SERVICES**

Total number of units (max 8 units per day) _____

Dates of Service: Start date for this request: _____ **End date of this request:** _____

Peer Recovery Support H0038 U8 15 min per unit **MEDICAID ONLY SERVICES**

Total number of units (max 8 units per day) _____

Dates of Service: Start date for this request: _____ **End date for this request:** _____

RESIDENTIAL FOR INITIAL SERVICE REQUESTS ONLY. **FOR CONTINUED STAY REQUESTS CALL 1-800-848-8327**

Track: (Must choose one)

- ☐ Adolescent Residential Services
- ☐ Adult Residential Services

Adult Res Intensity Level (Adult only, MN-based programs only)

- ☐ High (> 30 hours/month)
- ☐ Medium (15-29 hours/month)
- ☐ Low (5-14 hours/month)

Program/Modifiers (for MN based programs only)

(Must check all that apply)

- ☐ Co-Occurring Services
- ☐ Recipients with Children
- ☐ Special Populations
- ☐ Medical Services

Has the member been admitted to the program? ☐ **NO** ☐ **YES, ADMIT DATE** _____

Fax to: Medica Behavioral Health at 1-855-454-8155

Optum Behavioral is branded to Medica members as Medica Behavioral Health