 

**CRISIS INTERVENTION template/requirements (submitted by provider)**

**Scenario:** Completing a pre-authorization review for Crisis Intervention

**Effective Date:** 12/1/2015

Please Email (preferred) OR Fax the completed form to the contact information below:

EMAIL: [la.beh.auths@uhc.com](mailto:la.beh.auths@uhc.com%20)

FAX #: **1-855-202-7023**

***NOTE: Requests should be typed and not handwritten.******For adults 21 and older, an Assessment and LOCUS must be attached for all authorization requests.***

**REQUEST:**

* Provider name: Click here to enter text.
* Provider address: Click here to enter text.
* Provider telephone number: Click here to enter text.
* Provider email address: Click here to enter text.
* Assigned therapist: Click here to enter text.
* Tax ID # : Click here to enter text.
* NPI #: Click here to enter text.
* Date and time of request: Click here to enter text.
* Member name: Click here to enter text.
* Date of birth: Click here to enter text.
* Medicaid identification number: Click here to enter text.
* Diagnosis code: Click here to enter text.

**CRISIS INTERVENTION (request for initial authorization):**

* Date of crisis: Click here to enter text.
* Brief summary of crisis: Click here to enter text.
* Has a face-to-face assessment been completed by a Licensed Mental Health Professional (LMHP): Click here to enter text.
* Mental Status Exam (MSE) at the time of the assessment: Click here to enter text.
* Diagnosis: Click here to enter text.
* Treatment Plan (interventions and resolutions): Click here to enter text.
* Discharge Plan: Click here to enter text.
* Date services initiated (reminder: Crisis Intervention services are available for 14 days): Click here to enter text.
* Number of units requested: Click here to enter text.

**CRISIS INTERVENTION (request for continued authorization):**

* Treatment progress: Click here to enter text.
* Continued service needs: Click here to enter text.