

# Ohio Medicaid Authorization Form - Community Behavioral Health

Managed Care Entity Contact Information:

Member Information			
<b>Managed Care Entity (MCE)</b> <input type="checkbox"/> Medicaid Managed Care <input type="checkbox"/> MyCare Ohio <input type="checkbox"/> OhioRISE		<b>Date of Request</b> (mm/dd/yyyy)	
<b>Request Type</b> <input type="checkbox"/> Initial <input type="checkbox"/> Concurrent		<b>Service Request</b> <input type="checkbox"/> Routine <input type="checkbox"/> Expedited/Urgent** (select expedited for ACT and IHBT)	
<b>Member Name</b>		<b>Date of Birth</b> (mm/dd/yyyy)	
<b>Member Phone Number</b>		<b>Member Medicaid ID#</b>	
Provider Information			
<b>Billing Provider/Agency Name</b>		<b>Billing Provider/Agency Service Location</b>	
<b>Provider/Agency Contact Name</b>			
<b>Provider NPI</b>	<b>Provider Tax ID Number</b>	<b>Phone Number</b>	<b>Fax Number</b>
<b>Medicaid Provider Number</b>		<b>Provider Status</b> <input type="checkbox"/> MCE Contracted <input type="checkbox"/> MCE Non-contracted	
Service Requested			
	<b>Service Code Requested</b>	<b>Units/Visits Requested</b>	<b>Requested Start Date or Dates of Service</b>
Assertive Community Treatment*	<input type="checkbox"/> H0040		
MRSS Stabilization Service (more than 6 weeks)	<input type="checkbox"/> S9482		
Psychological/Neuropsychological Testing (> 20 hours per calendar year)	<input type="checkbox"/> 96130 <input type="checkbox"/> 96131 <input type="checkbox"/> 96136 <input type="checkbox"/> 96137 <input type="checkbox"/> 96132 <input type="checkbox"/> 96133		
SBIRT Services	<input type="checkbox"/> G0396 <input type="checkbox"/> G0397		
Psychiatric Diagnostic Evaluation	<input type="checkbox"/> 90791 <input type="checkbox"/> 90792		
Alcohol or Drug Assessment	<input type="checkbox"/> H0001		
Peer Support (more than four hours on same day)	<input type="checkbox"/> H0038		
Partial Hospitalization (Medicare only)	<input type="checkbox"/> G0410 <input type="checkbox"/> G0411		
Other Services/Out-of-network Providers			
OhioRISE Only Services			
Behavioral Health Respite*	<input type="checkbox"/> S5150 <input type="checkbox"/> S5151		
Intensive Home-Based Treatment*	<input type="checkbox"/> H2033 <input type="checkbox"/> H2015		
<b>Primary Diagnosis (ICD-10) – including provisional diagnosis</b>			

\*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
<p><b>Requests for Substance Use Disorder (SUD) Residential Treatment (H2034 and H2036) and Partial Hospitalization (H0015TG) should be submitted using the <a href="#">ODM 10276 “Substance Use Disorder Services Prior Authorization Request” form.</a></b></p> <p><b>The following information should be submitted to the MCE with this form:</b></p> <ul style="list-style-type: none"> <li>• Include service start date and referral source along with reason for services</li> <li>• Attach clinical documentation (e.g. Assessment Summary, ISP with Diagnostic Summary, Clinical Summary) to provide justification that the member meets criteria for a service.</li> <li>• Provide primary/secondary diagnoses and psychosocial issues/barriers to treatment</li> <li>• Provide pertinent medical and BH history including suicidal ideation/homicidal ideation risk</li> <li>• Provide treatment plan with target dates and discharge plan</li> <li>• <i>For continued stay requests please provide:</i> 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.</li> </ul>