Health Choice Prior Authorization and Continued Request Form for Behavioral Health Inpatient Facilities for Persons under Age 21

Submit completed forms and required documents to HCHHCICAUTHORIZATION@HEALTHCHOICEAZ.COM or fax to 480-760-4732.

Date of Request :

Type of Request: ☐ Prior Authorization ☐ Continued Stay ☐ Discharge

Member Name:

AHCCCS ID: Age: Gender:

Guardian: DOB:

Other Agency Involvement: ☐ DDD ☐ DCS ☐ Probation

Current Grade Level? ☐ IEP or 504 plan? Date:

Behavioral Health Home and Location:

Requesting BHMP Name: Phone Number:

Email:

Staff Submitting Request Name: Phone Number:

Email:

BHIF Name:

Provider AHCCCS ID:

AHCCCS ID:

ICD 10 Diagnosis code and narrative (Complete and update for all request)	
1. Code:	Narrative:
2. Code:	Narrative:
3. Code:	Narrative:
4. Code:	Narrative:
5. Code:	Narrative:

Prior Authorization Request (First Request Only)

How long in current location?

Clinical justification for BHIF request?

What treatment and interventions have been attempted to keep the member in their natural living environment or treatment setting?

AHCCCS ID:

Medical Necessity Requirements-Must meet one

Behaviors and Function over the **last three months** requiring requested level of care (Please check: Suicidal ☐ Aggression ☐ Self-harm ☐ Homicidal Thoughts or Behaviors ☐

Must describe and provide dates:

Significant impulsivity with poor judgment/insight and inability of environmental supports to maintain the individual despite adequate outpatient services/supports.

Must describe **behavior** and provide dates:

Risk of physiologic jeopardy

Must describe **behavior** and provide dates:

AHCCCS ID:

Risk of significant physical or sexual acting-out behavior with poor judgment and insight.

Must describe **behavior** and provide dates:

OR

Moderate functional impairment of self-care or self-regulation as evidenced by the documentation of psychiatric symptoms that clearly impair functioning, persist in the absence of stressors, and impair recovery from the presenting problem.

Must describe **behaviors/symptoms** and provide dates:

History of substance abuse and current use?

AHCCCS ID:

Discharge Planning and Treatment Goals

What is the specific improvement in reduction in symptoms, behaviors, and functioning at this level of care? Please provide specific and measurable goals?

Required Documents

CFT Note or Progress Note indicating need for this level of care.
Current Psychiatric Evaluation within last Year or current BHMP note
Medication records from Health Home
Copy of IEP, 504 plan, educational plan
Core Assesment and Annual Updates

Authorization is not a guarantee of payment.

AHCCCS ID:

Continued Stay Request (Must be updated every request)

Describe member's **specific** current symptoms and/or behaviors and/or functioning that continue to need current level of care?

What are the **specific** barriers to transitioning member to a less restrictive level of care?

How are these barriers being addressed? Please provide specific details for each barrier?

What is the specific discharge plan including placement after discharge?

AHCCCS ID:

Required Documentation that must be submitted with Continued Stay request.

Behavioral observation tools or scales to assess depression, anxiety, and psychosis (If applicable)
Current Medication Records
Rendering service providers documentation (i.e., monthly progress reports, progress notes, facility treatment plan, etc.)
CFT/ACT Notes or Progress Notes indicating continued need for this level of care
Updated Treatment Plan from Facility
Educational Testing/Assessments (If applicable)
Psychiatric/Psychological Testing or Assessments (If applicable)
Family Intake and Assessments (If applicable)