Intensive Outpatient

Humana Healthy Horizons in South Carolina



Please complete form in its entirety and return to: Email: <u>CorporateMedicaidCIT@humana.com</u> Fax: **833-441-0950**

Behavioral Health Service Request Form Choose The Appropriate Request Type FOR OUT OF NETWORK PROVIDERS ONLY PRIOR AUTHORIZATION IS REQUIRED FOR ALL SERVICES. Requests for prior authorization (with supporting clinical **Standard Request** information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed. By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to **Expedited Request** regain maximum function. Physician signature validating expedited request Date signed **Request Type** Authorization # **Request Date** Recertification Initial Change **Member Information** Date of Birth Last name First name Gender Male Female Phone Number Humana ID# Language Spoken If yes, please attach a copy of the insurance card or Other Ins. Yes No provide the name and contact information of the insurer. **Ordering Physician/Practitioner Information** NPI First Name Last Name Туре PCP Specialist Humana ID# Specialty Participating Yes No Phone Number Fax Number Street Address City, State Zip Name of Requestor Office Contact (If Different) **Treating Provider/Practitioner Information** NPT Last Name First Name Humana ID# Discipline/Specialty Street Address City, State Zip Phone Number Fax Number **Office Contact**

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

SCHL9W4EN0721

Humana Healthy Horizons in South Carolina is a Medicaid Product of Humana Benefit Plan of South Carolina, Inc.

Intensive Outpatient Behavioral Health Service Request Form

Treating Provider/Practitioner Information									
Last Name			First Name N			NPI	NPI		
Street Address			City, State			Zip			
Phone Number			Fax Number			Office Contact			
Requested Services									
Start Date End Dat		e -		Transition of Care		Continuation of Care			
			Yes No		Yes No				
Primary CPT/ICD-10 or HCPS Code(s) and Hours/Units of Each Requested									
Indicate any change in diagnostic presentation.									
Axis I	kis I R/O								
Axis II						R/O			
Axis III									
Axis IV (Psychological Stressors)									
Axis V –	Current GAF			High	est GAF in Past Ye	ear			
Presenting Problem and Patient Symptomology									
Include the date the problem(s) beg			an along with the duration			Psychiatrist Yes involved in care? No			
Current Symptoms (Check all Apply)									
			Current S	Symptoms	s (Check all Apply)	1			
Suicio Homi	dal/ icidal Ideation		Current S aired Atte entration	ntion/	(Check all Apply) Hopelessness/ Helplessness			/Physical/ Abuse	
Homi	icidal Ideation	Conc	aired Atte	ntion/	Hopelessness		Sexual		
Homi Subst		Conc Self-I	aired Atte entration	ntion/	Hopelessness/ Helplessness	/	Sexual Cruelty	Abuse	
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Rationale
Identify the treatment goals.
Describe how the treatment plan will affected the treatment outcomes.
(Please attach a copy of the current treatment plan)
Are there other reasons treatment is necessary?
Are there other reasons treatment is necessary?
Is this treatment court or recearch related or for admission to a preammer excepted?
Is this treatment court or research related or for admission to a program or school?
Has there been any prior outpatient treatment? Yes No If yes , please specify the dates.
Treatment failure? Yes No If yes , please specify the previous treatment.
Current Medications (Please indicate if the member is compliant)



