Humana
Healthy Horizons™ in South Carolina

Healthy Connections

PHP and IOP Behavioral Health Authorization Request Form

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

Place of Service	☐ Office ☐ Outpatient Hospital ☐ Psychiatric Facility-Partial Hospitalization ☐ Community Mental Health Center
Treatment Focus	☐ Mental Health ☐ Substance Use Disorder ☐ Dual Diagnosis

Member Information

Last Name	First Name	Date of Birth
Phone Number	Humana ID#	Gender ☐ Male ☐ Female
Other Ins. ☐ Yes ☐ No	If yes, please attach a copy of the insurance card or provide the name and contact information of the insurer.	Language Spoken

Treating Provider/Practitioner Information

Last Name	First Name	NPI
Humana ID#	Discipline/ Specialty	
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Facility/Agency Information

Name	Facility ID	NPI
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Service type Requested	REV/HCPCS Code(s) and Number of Days/Units Requested		
PHP	REV/HCPC Code (s):	Number of Days/Units:	
IOP	REV/HCPC Code (s):	Number of Days/Units:	
Service Request Start Date:	Projected Length of Stay:	Transition of Care ☐ Yes ☐ No	Continuation of Care ☐ Yes ☐ No

Diagnosis - Code and Description

Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	

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

SCHL9W9EN0721

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Diagnosis - Code and Description

Are services requested court ordered? ☐ Yes ☐ No If **yes**, please submit a copy of the court order and all supporting documentation.

Clinical Details

Current Symptoms and Behaviors:

Is there a trigger event identified? ☐ **Yes** ☐ **No** Please describe:

Is member motivated for treatment? ☐ **Yes** ☐ **No**	Is Transportation available? ☐ **Yes** ☐ **No**

Current Risks

Risk level scale: **0** = None; **1** = Mild, ideation only; **2** = Moderate, ideation with either a plan or history of attempts; **3** = Severe, ideation **AND** plan, with either intent or means.

Check the risk level for each category and check all boxes that apply.

Risk of self (SI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	with	☐ Ideation ☐ Intent ☐ Plan ☐ Means
Risk of others (HI)	☐ 0 ☐ 1 ☐ 2 ☐ 3	with	☐ Ideation ☐ Intent ☐ Plan ☐ Means

Current serious attempt or non-suicidal self injury	☐ Yes ☐ No If **yes**, describe below. Check: ☐ SI ☐ HI

If above checked **yes**, please describe :

Date of most recent attempt or non-suicidal self injury:

Prior serious attempt or non-suicidal self injury	☐ Yes ☐ No If **yes**, describe below. Check: ☐ SI ☐ HI

If above checked yes, please describe :

Substance Abuse/Co-Morbidity

Does the member have a current Substance Use Disorder? ☐ **Yes** ☐ **No**

Is the member currently intoxicated? ☐ **Yes** ☐ **No**
If **yes**, please list substance (s) used:

Please check off all withdrawal symptoms the member is experiencing :

☐ Hand Tremors	☐ Impaired attention /memory	☐ Psychomotor agitation
☐ Sweating/Weakness	☐ Nausea/Vomiting	☐ Anxiety/Irritability
☐ Nystagmus	☐ Fluctuating vital signs	☐ Changes in Mood/Personality
☐ Insomnia	Vital Signs:	

Has member been medically cleared? ☐ **Yes** ☐ **No**

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Additional Data to Support Request

Is a psychiatrist involved in the member's care? ☐ **Yes** ☐ **No**
If **yes**, when was the member last seen and what services are being rendered?

Is member currently receiving Outpatient services? ☐ **Yes** ☐ **No**

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? ☐ **Yes** ☐ **No**

Level of Care	Name or Provider / Facility	Dates	Successful
Inpatient			☐ Yes ☐ No
Residential			☐ Yes ☐ No
IOP / PHP			☐ Yes ☐ No
Outpatient			☐ Yes ☐ No
Intensive Community Based Treatment			☐ Yes ☐ No

If treatment was not successful, please explain:

Please explain why the member cannot be managed safely in a less intensive level of care:

Support System and Performance

Relationship/Supports (identify issues/concerns: Is support available / Is support substance free?)

What are the environmental/community stressors and/or supports that contribute to the member's clinical status?

Role performance school/work issues/concerns:

Describe the member/family engagement in treatment:

Current living situation: ☐ Homeless ☐ Independent ☐ Family
☐ Foster home ☐ Incarcerated ☐ other:

Is the member at risk of legal intervention or out-of-home placement? ☐ **Yes** ☐ **No** (describe)

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Current Medications (Psychotropic and Medical)			
Medication	Dosage	Frequency	Compliant
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**
			☐ **Yes** ☐ **No**

Are there any medication contraindications? If **yes**, please describe:

Discharge Plan upon Admission:

Attachments

☐ Current Treatment Plan ☐ Biopsychosocial Assessment ☐ Court Order
☐ Psychiatric Report ☐ Other:

Continued Stay Reviews

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for partial hospitalization or intensive outpatient services. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Continued symptoms/behaviors:

Scale: **0** = None; **1** = Mild; **2** = Moderate; **3** = severe; **N/A** = Not assessed

Check the current level of impairment for each category and provide a brief description:

Symptom	Scale	Description
Functioning	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Cravings/preoccupation with substances	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Withdrawal symptoms	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Ability to follow instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Perform ADLs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Drug-seeking behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

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Continued Stay Review			
Types of services offered	Total number of sessions attended	Total number of sessions	Is member cooperative with treatment? If **no**, please provider an explanation
Individual Therapy			☐ Yes ☐ No
Group Therapy			☐ Yes ☐ No
Substance Abuse Counseling			☐ Yes ☐ No
Family Therapy			☐ Yes ☐ No
Psychiatric Interventions			☐ Yes ☐ No

Current Medications (Psychotropic and Medical)		
Name of Provider / Facility	Dates	Compliant
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
Detail any updates or changes to the discharge plan:		

Attachements		
☐ Current Treatment Plan	☐ Biopsychosocial Assessment	☐ Court Order
☐ Psychiatric Report	☐ Other:	

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