Humana

Behavioral Health Commercial/Medicare Authorization Request Form (Initial and Subsequent Review)
Inpatient, Sub-acute and Residential Requests

Note: This form may be used by providers to provide clinical information to substantiate behavioral health inpatient authorization requests via fax. Providers are not required to use this form and alternatively may complete requests via phone as indicated below. For continued-stay reviews, please provide current information. Please complete all fields of this form.

This form does not guarantee payment by Humana Inc. Responsibility for payment is subject to membership eligibility, benefit limitations and interpretation of benefits under applicable subrogation and coordination-of-benefits rules. For any other services, it will be necessary to obtain an additional authorization. Attach supporting documentation (medical records, progress notes, lab reports, radiology studies, etc.) if needed. Please review guidance provided by www.CMS.gov and "Humana® Prior Authorization List" for further information.

Should you require assistance completing form, and need to reach Humana via phone please call: Medicare Phone: 1-844-825-7898 Commercial Phone: 1-844-825-7899 **Please complete form along with any applicable supporting documentation to:** Fax: 469-913-6941.			
MEMBER INFORMATION			
Last Name:		**First Name:**	
Date of Birth:		**Humana Member ID Number:**	
Phone Number:		**Living Situation (i.e., Homeless, SNF):**	
Current Address:			
FACILITY/PROVIDER INFORMATION			
Facility NPI (National Provider Identifier):		**Facility TIN (Tax Identification Number):**	
Facility is Medicare certified:	☐ **Yes** ☐ **No**	**Facility name:**	
Facility address:			
Phone number:		**Fax number:**	
Attending provider NPI:		**Attending provider TIN:**	
Attending provider Name:			
Attending provider Address:			
Phone number:		**Fax number:**	
AUTHORIZATION INFORMATION			
Authorization number, if applicable:		**Service date and time:**	
Authorization type:	Inpatient		
Is the member currently Inpatient:	☐ Y/ ☐ N	**What is the current Length of Stay (LOS):**	**Estimated LOS:**
Authorization type: (Inpatient):	☐ **Inpatient Psychiatric**		
	☐ **Inpatient Detox**		
	☐ **Substance Abuse Inpatient Rehab**		
	☐ **Residential Treatment**	☐ Psychiatric Residential	☐ Substance Abuse Residential

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Place of service:	☐ Freestanding Psychiatric Facility			
	☐ Inpatient Services			
	☐ Residential Substance Abuse Treatment Facility			
Primary DX code:		**Secondary DX Code:**		**Did DX code change**? ☐ Y / ☐ N
Revenue codes:				
Requested days/units:				

CLINICAL INFORMATION CHECKLIST

Please submit the requested clinical information below. If you have previously completed this form and wish to provide clinical information for a ***subsequent review*,** please update the clinical information section of this form below.

Admission status:	☐ **Voluntary**		☐ **Involuntary**	
Observation status:	☐ **Standard Q-15**		☐ **Other (describe):**	
Readmission within 30 days:	☐ **Yes** ☐ **No**	**Reason for readmission:**		
Date of Problem Onset:		**Duration of current episode:**		**Is the Member under the Care of an OP Psychiatrist?** ☐ Y / ☐ N

PAST TREATMENT HISTORY

Level of care:	Number of admissions/sessions:	Date/s of treatment (MM/YY-MM/YY):
Inpatient within last six months		
Residential within last year		
PHP (Partial hospitalization) within last year		
IOP (Intensive outpatient program) within last year		
Outpatient Therapy within last year		
ECT (Electroconvulsive therapy)/TMS (Transcranial magnetic stimulation) within last year		

CURRENT RISK

Please select initial reason for admission and briefly describe section below.

☐ **Substance abuse** ☐ **Danger to self** ☐ **Danger to others** ☐ **Psychosis**

Please include relevant information here.

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CURRENT RISK			
Risk Level Scale: 0 = None; 1 = Mild (Ideation Only); 2 = Moderate (Intention 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 the boxes that apply.			
Risk to self (SI) *within past 24 hours*	□ 0 □ 1 □ 2 □ 3	**With:** □ **Ideation** □ **Intent** □ **Plan**: _____ □ **Means**	
Risk to others (HI) *within past 24 hours*	□ 0 □ 1 □ 2 □ 3	**With:** □ **Ideation** □ **Intent** □ **Plan**: _____ □ **Means**	
Current self-harm or suicide attempt:	□ Yes □ No (if yes, describe below)	**Check:** □ **SI** / □ **HI**	**Date of most recent attempt:**
If checked yes above, please describe:			
Prior self-harm or suicide attempt:	□ Yes □ No (if yes, describe below)	**Check:** □ **SI** / □ **HI**	**Date of prior attempt:**
If checked yes above, please describe:			

CURRENT IMPAIRMENTS		
***Please provide brief description of symptoms below*.** Check impairment level using scale below. **Scale: 0 = None; 1 = Mild; 2 = Moderate; 3 = Severe; N/A = Not Assessed**		
Mood disturbance (e.g., depression, mania**):**		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Anxiety:		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Psychosis (e.g., delusions, hallucinations**):**		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Cognition, memory, thinking and orientation:		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Active impulsiveness/ recklessness/aggression (please specify**):**		□ **0** □ **1** □ **2** □ **3** □ **N/A**
ADLs (e.g., appetite, sleep or hygiene concerns**):**		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Significant weight changes (+/-**):**		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Active medical/physical comorbidities (e.g., current UTI, HTN, DM**):**		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Job/school performance:		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Social/marital/family issues:		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Legal issues:		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Stressors:		□ **0** □ **1** □ **2** □ **3** □ **N/A**
Significant MD/therapy concerns:		

Mental Status Exam (MSE**):**	
Cognitive scores (e.g., MOCA, SLUM, MMSE**):**	
Vital Signs:	
Substance abuse rating scales (e.g., CIWA, COWS**):**	
Relevant labs (e.g., UA, UDS, mood stabilizer levels, abnormal labs**):**	
Post-discharge barriers:	
Living conditions and home supports:	
Anticipated discharge plan:	

PSYCHIATRIC HOME MEDICATIONS

Medication name/s:	Dose/frequency:	Time period:	Response/compliance:	Side effects:	Current med?
					☐
					☐
					☐
					☐
					☐
					☐

PSYCHIATRIC CURRENT MEDICATIONS
(including standing meds, PRNs and ETOs in last 24 hours):

Medication name/s:	Dose/frequency:	Start date/change date:	Response/compliance:	Side effects:	Current med?
					☐
					☐
					☐
					☐
					☐
					☐
					☐

CURRENT MEDICAL MEDICATIONS

Signature:		**Date:**	