Humana

Behavioral Health Commercial/Medicare Authorization Request Form (Initial and Subsequent Review)

Outpatient Requests (Applied Behavioral Analysis, Partial Hospitalization, Transcranial Magnetic Stimulation)

Note: This form may be used by providers to provide clinical information to substantiate behavioral health outpatient authorization requests via fax. Providers are not required to use this form and alternatively may complete requests via phone as indicated below. For subsequent 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 the form, and need to reach Humana via phone please call: Medicare phone: **844-825-7898** Commercial phone: **844-825-7899** **Please complete the 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:**		
Are you requesting a Letter of Agreement (LOA):	☐ **Yes**	☐ **No**		
AUTHORIZATION INFORMATION				
Authorization number, if applicable:		**Service date and time:**		
Authorization type:	Outpatient			
Is the member currently in treatment:	☐ Y/ ☐ N	**What is the current Length of Stay (LOS):**		**Estimated LOS:**
Authorization type: (Outpatient):	☐ **Applied behavioral analysis (ABA)**			
	☐ **Partial hospitalization (PHP)**			
	☐ **Transcranial magnetic stimulation (TMS)**			

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Place of service:	☐ Freestanding psychiatric facility			
	☐ Outpatient services			
	☐ Residential substance abuse treatment facility			
Primary DX code:		**Secondary DX Code:**		**Did DX code change?** ☐ Y / ☐ N
ABA revenue codes (list appropriate H or 9 codes as per contract):				
PHP revenue codes (0912, 0913):				
TMS revenue codes (90867, 90868, 90869):				
Requested days/procedures/units/visits:				

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.

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/SYMPTOMS

Please select initial reason for treatment and briefly describe in the section below.

☐ **Substance abuse** ☐ **Danger to self** ☐ **Danger to others** ☐ **Psychosis** ☐ **N/A**

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 a 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 a brief description of symptoms below*.** Check impairment level using scale. **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):		

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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:	

ABA SPECIFIC INFORMATION - ATTACH TREATMENT PLAN TO THIS FORM

TMS SPECIFIC INFORMATION

TMS device (must be FDA approved):			
Severity of the disorder impacting the safety of the patient and thus resulting in recommendation for TMS treatment?	□ Patient is unable to function at work/school.		
List any augmentation strategies tried to the right. Examples include lithium, thyroid hormone, stimulants, dual anti-depressants, anti-psychotics, therapy and/or ECT.	□ No		
Repeat treatment request:	□ No	□ Yes	Past TX dates:
		Improvement in PHQ-9:	Number of TX completed:
Current depression rating scales – can include pre-TMS treatment and post-TMS treatment if treatment has been rendered.	□ Yes, include dates:		
Medical assessment completed and requesting MD certifies that patient is medically appropriate for TMS:	□ No		
Other medical conditions that may cause difficulty/complications with proposed treatment (e.g., cardiac DX):			
Comorbid medical conditions that might warrant TMS as the preferred treatment modality:	□ Discussed risks and benefits of proposed treatment with patient and/or family.		
What is the informed consent process?	□ Informed consent provided by patient and/or legal guardian.		
	□ Informed consent provided by patient and/or legal guardian.		

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PSYCHIATRIC MEDICATIONS

Note: Evidence of at least four medications trials from earliest to latest including two different agent classes during this episode are required for TMS requests:

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

CURRENT MEDICAL MEDICATIONS

Signature:		Date:	