



Behavioral Health Authorization Request Form

Requests can be submitted electronically via the Provider Portal: <https://smnyportal.valence.care>

Fax completed form to: 1-866-865-9969

Phone number: 1-844-990-0255

* = Required Information

*Requestor's Contact Name:

*Requestor's Contact Number:

PATIENT INFORMATION

*Member Name:

*Date of Birth:

*Member ID Number:

Member Phone Number:

*Service is:

Elective/ Routine

Expedited/ Urgent

Select Expedited/Urgent to prevent serious deterioration in health or ability to regain maximum function.

Extension to Authorization _____

Continuity of Care Concern:

SERVICE TYPE

Inpatient Mental Health

Intensive Outpatient (IOP)

Electro Convulsive Therapy

Inpatient Chemical Dependency

Outpatient Counseling

Psych Testing

Partial Hospitalization

Residential Treatment Center

Other:

Community Based Services/ Case Management

PROCEDURE INFORMATION

*ICD-10 Diagnosis:

Diagnosis Description:

*CPT Code: _____ Units: _____

CPT Code: _____ Units: _____

CPT Code: _____ Units: _____

CPT Code: _____ Units: _____

CPT Code: _____ Units: _____

CPT Code: _____ Units: _____

* Date(s) of Service:

PROVIDER INFORMATION

Ordering Provider:

Primary Care Physician

*Name: _____

*NPI: _____

*TIN: _____

*Fax: _____

Phone _____

*Address: _____

Servicing Provider:

Same as Ordering

*Name: _____

*NPI: _____

*TIN: _____

*Fax: _____

Phone _____

*Address: _____

Facility:

N/A

*Name: _____

*NPI: _____

*TIN: _____

*Fax: _____

Phone _____

*Address: _____

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ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED & RETURNED.

COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED.

LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION

Note: Utilization Management (UM) functions are performed by Evolent Health

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

Rev 02262020

CARE COORDINATION

UR Department	Discharge Planner	Health Plan Care Coordinator
<input type="checkbox"/> N/A	<input type="checkbox"/> N/A	<input type="checkbox"/> N/A
Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Fax: _____	Fax: _____	Fax: _____
Email: _____	Email: _____	Email: _____

MEDICATION

Is Member on current psychiatric and or medical medications? If yes, please complete below. Use separate sheet if more space is needed.

Medication	Dosage	Response	Medication	Dosage	Response

SYMPTOM CHECK LIST (Not a substitute for submitting clinical information)

Psychosis: <input type="checkbox"/> Command <input type="checkbox"/> Hallucinations <input type="checkbox"/> Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Dissociation <input type="checkbox"/> Loose Associations <input type="checkbox"/> Paranoia Anxiety: <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Chronic Worrying <input type="checkbox"/> Obsessive Thoughts <input type="checkbox"/> Compulsive Behaviors	Safety: <input type="checkbox"/> Suicidal ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means <input type="checkbox"/> Homicidal Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Means <input type="checkbox"/> Property Destruction <input type="checkbox"/> Aggression <input type="checkbox"/> Verbal <input type="checkbox"/> Physical <input type="checkbox"/> Fire Setting <input type="checkbox"/> Self-Harm	Mood: <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Hypomania <input type="checkbox"/> Mania <input type="checkbox"/> Excessive Motor Activity <input type="checkbox"/> Flight of ideas <input type="checkbox"/> Grandiosity <input type="checkbox"/> Pressured Speech <input type="checkbox"/> Sleep Disturbance <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Hopelessness	Substance Use <input type="checkbox"/> Abuse <input type="checkbox"/> Dependence <input type="checkbox"/> N/A Detoxing Currently <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CIWA Score ____ <input type="checkbox"/> COWS Score ____ <input type="checkbox"/> CINA Score ____ <input type="checkbox"/> History of withdrawal seizures <input type="checkbox"/> History of delirium tremens <input type="checkbox"/> Co-occurring medical condition *If yes, list here _____	Developmental Disorders: <input type="checkbox"/> Autism <input type="checkbox"/> Asperger's <input type="checkbox"/> Mental Retardation <input type="checkbox"/> Other Medication Adherence: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Name of Medication: _____ Date Last Took: _____	Other Symptoms: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ Progress: <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Regressed
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CLINICAL INFORMATION

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