# Addictive and Mental Disorders Division Mental Health Prior Authorization Review Form

*All forms must be typed. Handwritten or incomplete forms will be returned.*

*Refer to the Addictive and Mental Disorders Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health for information pertaining to Utilization Management process and requirements.*

**Requested Service Type:**

PACT (Complete Page 1,2 & Form A)  ICBR (Complete Page 1,2 & Form B  AGH (Complete Page 1,2 & Form C)

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| **Provider Information** | | | | | | | | | | |
| Provider Name: | Enter text. |  | Address: | | Enter text. | | |  | City: | Enter text. |
| Phone Number: | Enter text. |  | Fax: | Enter text. | |  | Provider ID: | | Enter text. | |

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| **Demographics** | | | | | | | | | | | | | |
| Member Name: | Enter text. |  | Birthdate: | | Enter text. |  | Medicaid # | | | | | Enter text. | |
| Address: | Enter text. |  | City: | Enter text. | | | |  | Zip: | | Enter text. | | |
| Phone: | Enter text. |  | Cell: | Enter text. | | | |  | Social Security #: | | | | Enter text. |
| Does member have a legal guardian/power of attorney?  Yes  No | | | | | | | | | | | | | |
| Guardian Name: | Enter text. |  |  | Relationship to member: | | | | Enter text. | | | | | |
| Address: | Enter text. |  | City: | Enter text. | | | |  | Zip: | Enter text. | | | |
| Phone: | Enter text. |  | Cell: | Enter text. | | | |  |  | | | |  |

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| **Primary SDMI Diagnosis** | | | | | | |
| Primary SDMI Diagnosis: | | Enter text. | ICD-10 Code: | |  | Enter text. |
| Description: | Enter text. | | | | | |
| Additional diagnosis relevant to treatment (Enter N/A if not applicable): | | | | Enter text. | | |
| The member meets the criteria for having an SDMI, including specific functional impairment criteria: | | | | | | |
| Yes  No | | | | | | |
| Has the member been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at the Montana State Hospital in the past 12 months?  Yes  No | | | | | | |

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| **Section A** | | | |
| Initial assessment completion date: | Enter text. | Completed By: | Enter text. |
| Is the initial assessment attached?  Yes  No Is the latest clinical assessment attached?  Yes  No | | | |
| Date of last clinical assessment: Enter text. | | Requested Start Date: Enter text. | |

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| **Section B: Hospitalizations in the past three years:** (attach additional sheets if needed) | | | |
| **Facility Name** | **Admission Date** | **Discharge Date** | **Reason for Admission** |
| Enter text. | Enter text. | Enter text. | Enter text. |
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| **Section C: Current Medication- Psychiatric and Medical.** (attach additional sheets if needed) | | |
| **Medication** | **Dose** | **Schedule** |
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| **Licensed Mental Health Professional Name:** | | Enter text. |  | **Credentials:** | Enter text. |
| **Signature:** | Enter text. | |  | **Date:** | Enter text. |

**Addictive and Mental Disorders Division**

**Form A - Program of Assertive Community Treatment (PACT)**

**IMPORTANT - In determining eligibility, all criteria that is checked must include supporting individualized information. Requests missing individualized information will be considered incomplete and will be denied.**

**Section D: Member must meet the SDMI criteria as described in the manual and two or more of the following criteria that are indicators of continuous, greater than eight hours per month, high-service needs: (attach additional sheets if needed)**

The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates the following due to the SDMI: significantly impaired interpersonal or social functioning; significantly impaired occupational functioning; impaired judgment; poor impulse control; and/or lack of family or other community or social supports. (Enter individualized information below)

Enter text.

Inability to consistently perform the range of practical daily living tasks required for basic adult functioning in the community or persistent or recurrent failure to perform daily living tasks without significant support or assistance from others. (Enter individualized information below)

Enter text.

Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role. (Enter individualized information below)

Enter text.

Inability to maintain a safe living situation. (Enter individualized information below)

Enter text.

Two or more admissions per year into acute psychiatric hospitals, crisis stabilization facilities, or psychiatric emergency services. (Enter individualized information below)

Enter text.

Intractable (persistent or very recurrent) or severe major symptoms which present with affective, psychotic, or at risk for harm to self or others. (Enter individualized information below)

Enter text.

Co-existing SUD with a duration of greater than six months. (Enter individualized information below)

Enter text.

High risk or recent history of criminal justice involvement. (Enter individualized information below)

Enter text.

Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of being homeless. (Enter individualized information below)

Enter text.

Residing in an inpatient bed or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available. (Enter individualized information below)

Enter text.

Inability to participate in traditional outpatient services.

Enter text.

# Fax completed Page 1 & 2 and Form A to:

# Telligen Medicaid Administration

**Fax: 1-833-574-0650 Phone: 866-545-9428**

**Addictive and Mental Disorders Division**

**Form B – Intensive Community-Based Rehabilitation (ICBR)**

**SECTION D: Is this a referral from Montana State Hospital (MSH) or Montana Mental Health Nursing Care Center (MMHNCC)?  Yes  No (If no, stop here! The member is not eligible for service.**

**SECTION E: the member must meet the SDMI criteria as described in the Manual and: (attach additional sheets if needed)**

Must be an inpatient in the MSH or MMHNCC and is ready for discharge. (Enter individualized information below)

Enter text.

Requires a structured treatment environment to be successfully treated in a less restrictive setting. (Enter individualized information below)

Enter text.

Has a history of institutional placement, at least one full year of institutional care in the past three years, as well as a history of repeated unsuccessful placements in less intensive community – based programs. (Enter individualized information below)

Enter text.

Exhibits an inability to perform daily living activities in an appropriate manner because of the SDMI. (Enter individualized information below)

Enter text.

Presents with SDMI symptoms of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by outpatient mental Health Services. (Enter individualized information below)

Enter text.

# Fax completed Page 1 & 2 and Form B to: Magellan Medicaid Administration

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**Addictive and Mental Disorders Division**

**Form C – Adult Group Home**

**SECTION D: Member must meet SDMI criteria as described in the manual and: (Attach additional sheets if needed)**

The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates three or more of the following due to the SDMI: significantly impaired interpersonal or social functioning; significantly impaired occupational functioning; impaired judgment; poor impulse control; and/or lack of family or other community or social supports. (Enter individualized information below)

Enter text.

Due to the SDMI, the member exhibits an impaired ability to perform daily living activities in an appropriate manner. (Enter individualized information below)

Enter text.

The member exhibits symptoms related to the SDMI that are served your enough that a less intensive level of service would be insufficient to support the member in an independent living setting or the member is currently being treated or maintained in a more restrictive environment or requires a structured treatment environment to be successfully treated in a less restrictive setting. (Enter individualized information below)

Enter text.

# Fax completed Page 1 & 2 and Form C to: Magellan Medicaid Administration

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