AmeriHealth Caritas New Hampshire

Mental Health Inpatient, Partial Hospitalization, or Intensive Outpatient Authorization Form

Submit to Utilization Management
Fax: 1-833-469-2264
For assistance, please call 1-833-472-2264

Please note: Authorization is based on medical necessity. Incomplete or illegible forms will delay processing. Please provide all pertinent clinical information, including assessments and/or treatment plans. A telephonic review may be required if additional clinical information is required to determine medical necessity.

Psychological and neuropsychological testing requests are submitted on the AmeriHealth Caritas New Hampshire Psychological Testing Request Form.

Requested services		
Insert service name: Insert service code:	☐ Precertification ☐ Continued stay	Date of admission: Estimated length of stay: Units/hours requested:

Member information		
Name (last, first, MI):		
Date of birth:	Medicaid or member ID number:	
Address:		Phone number:
Emergency contact:	Phone number:	Relationship:
If dependent adult, legal guardian:		Phone number:
Member's DSM diagnoses:		

Provider information			
Facility name:			
Facility address:			Facility NPI/tax ID:
Facility phone number:	Facility fax number:	UM review contact name:	
Attending physician:		NPI/tax ID:	

Medications

Medications, if known, including dosages, and prescriber (e.g., primary care provider [PCP] or psychiatrist) **or** attach a medication list:

Current treating psychiatrist, if applicable (name/date last seen):

Medication name	**Dosage**	**Frequency**	**Date of last change if applicable**	**Type of change**
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New
				☐ Increase ☐ Decrease ☐ D/C ☐ New

Additional information if applicable:

Current risk/lethality		
Suicidal: ☐ No ☐ Yes If yes, please answer questions below.		
Active recurrent thoughts: ☐ Yes ☐ No	Making threats: ☐ Yes ☐ No	Plan: ☐ Yes ☐ No
Available means: ☐ Yes ☐ No If yes, please explain:		
Command hallucinations: ☐ Yes ☐ No If yes, please explain:		
History of suicide attempts: ☐ Yes ☐ No If yes, please explain:		

Current risk/lethality		
Homicidal thoughts: ☐ No ☐ Yes If yes, please answer questions below.		
Active recurrent thoughts: ☐ Yes ☐ No	Making threats: ☐ Yes ☐ No	Plan: ☐ Yes ☐ No
Available means: ☐ Yes ☐ No If yes, please explain:		
Command hallucinations: ☐ Yes ☐ No If yes, please explain:		
History of homicide attempts: ☐ Yes ☐ No If yes, please explain:		
Assault/violence: ☐ Yes ☐ No If yes, please explain:		
History of assault/violence: ☐ Yes ☐ No If yes, please explain:		

Mental status exam (mood, affect, or hallucinations; check all that apply)								
Appearance:	☐ Neat	☐ Well	☐ Groomed	☐ Disheveled	☐ Dirty	☐ Drowsy	☐ Intoxicated	☐ Casual
Eye contact:	☐ Adequate	☐ Intense	☐ Staring	☐ Avoidant	☐ Guarded	☐ Poor	☐ Other	
Speech:	☐ Normal	☐ Soft	☐ Loud	☐ Slowed	☐ Slurred	☐ Pressured	☐ Repetitive	
Interaction:	☐ Pleasant	☐ Cooperative	☐ Angry	☐ Guarded	☐ Suspicious	☐ Apathetic	☐ Aloof	☐ Passive
Motor activity:	☐ Appropriate	☐ Restless	☐ Hyperactive	☐ Repetitive	☐ Agitated			
Affect:	☐ Full Range	☐ Flat	☐ Blunted	☐ Labile	☐ Constricted	☐ Tearful	☐ Inappropriate	
Mood:	☐ Calm	☐ Anxious	☐ Depressed	☐ Manic	☐ Hostile	☐ Sad	☐ Euphoric	
Thought process:	☐ Coherent	☐ Goal Directed		☐ Blocking	☐ Loose Associations		☐ Tangential	
Thought content:	☐ Coherent	☐ Suicidal	☐ Homicidal	☐ Hallucinations		☐ Grandiose	☐ Delusional	
Orientation:	☐ Oriented	☐ Person	☐ Place	☐ Disoriented				

Presenting problem
Current clinical information (suicidal ideation, homicidal ideation, psychosis, mood/affect, sleep, appetite, withdrawal symptoms, chronic substance use disorder [SUD]):
Describe member's functioning: ☐ Activities of daily living (ADLs): ☐ Social settings: ☐ Educational/occupational: ☐ Current living environment: Indicate the recommendations of the member's assessment/evaluation and treatment plan:

Treatment history and current treatment participation
Previous mental health (MH)/SUD inpatient, rehab, or detox:
Outpatient treatment, psychological testing, crisis intervention, or community-based services:
Is the member participating in individual or group therapy? ☐ Yes ☐ No
Explain the member's clinical treatment plan:
How long has the member experienced mental illness and/or SUD?
Family involvement/support system:
Substance use: ☐ Yes ☐ No If yes, please explain how SUD is being treated and provide information on substances used, first use, and last use:

Discharge planning	
Discharge planner name:	
Phone number:	Fax number:
Place of residence upon discharge:	
Address:	
Treatment setting/services upon discharge:	
Provider of services, if known:	
Has a post-discharge seven-day follow-up aftercare appointment been scheduled? ☐ Yes If yes, complete below.	
Provider name:	Date and time of appointment:
☐ No If no, explain:	
Identify collaboration needs (please indicate if collaboration is needed with any of the below, including contact name and phone number): ☐ Child or adult protective agency: ☐ Group home: ☐ Nursing or nursing home facility: ☐ Residential program: ☐ Jail/prison/court system: ☐ Long-term services and supports (LTSS)/waiver programs: ☐ Other:	

Provider signature: Date: