South Carolina Department of Mental Health CMHC
Treatment Review & Authorization Request

☐ Initial Authorization/Initial Clinical Assessment/POC
☐ Routine Request: (Up to 14 days)

☐ Re-Authorization/Plan of Care
☐ Urgent Request: (Within 72 hours) – Services are needed to stabilize the patient and prevent deterioration. Client needs significant and immediate supportive interventions.

Admission Date: _____

Date of Request: _____

Managed Care Organization				
☐ **Select Health** Phone: 866.341.8765 Fax: 888.796.5521	☐ **Blue Choice** Phone: 866-902-1689 opt. 3 Fax: 877-664-1499	☐ **Molina** Phone: **(855) 237-6178** Fax: (866) 423-3889	☐ **Absolute Total Care** Phone: (866) 534-5976 Fax: 866 694-3649	☐ **WellCare** Phone (provider services and urgent requests): (888) 588-9842 Fax: (888) 343-5364

Provider(s) Information		
CMHC Contact Person:	Phone #: Fax #:	Ordering Physician: NPI#:

Community Mental Health Center Information		
Name:	Medicaid Provider #:	NPI:

Member Information			
Name:	Date of Birth:	DMH Identification #:	Medicaid#

Address:	Mobile Phone #: Home Phone #:	Contact Information: Relationship: Phone #:

Current Diagnoses

Psychiatric /Co-Occurring Substance Disorder:
Medical:

Current Medications (medication name, dosage, frequency and prescriber): ☐ **None** ☒ **Yes. See PMO**
Adherent to Medication Regimen: ☐ **Not applicable** ☐ **See PMO**

Justification for Authorization:

Expectation for client's improvement:

Previous and/or current Treatment history and Outcome: ☐None ☐ Yes. See Initial Clinical Assessment

Discharge/Transition Plan: (See attached POC) Inpatient Admission in the last 90 days: ☐None ☐Yes

Date of Last Assessment:
Significant changes in member's life since last assessment-
☐ Not applicable. This is an initial request for services
☐ No significant changes
☐ Changes noted as follows:

Transportation Available: ☐Yes ☐None Other barriers to treatment: ☐None ☐ Yes:
Referral to Clinical Care Coordination: ☐Yes ☐Not applicable

Overall Motivation to Treatment:
☐ Good – Willing to follow up with recommendations and actively participate in treatment
☐ Somewhat - Wants treatment, but sometimes forgets to complete action steps/plans or follow up with recommendations
☐ Poor – ☐Has or had difficulties following up with treatment because of poor insight
☐Not fully engaged or is ambivalent about the benefits of treatment

☐Denies having any problems and/or blames other for his/her problems

☐Other:

Family Involvement: ☐Active ☐ Limited ☐ None ☐ Not Applicable

Explain any less than active involvement:

Participation in Community Supports: ☐ Not at this time ☐ As follows:

Other Supports: ☐ None at this time ☐As follows:

Treatment Request

Treatment Request: please check services being requested and explain the program to be provided:

☐Behavior Modification:_____

1. Service Code being requested: H2014 2. Number of Units: _____ 3. Frequency: _____(weeks)

☐Psychosocial Rehabilitation Services: _____

1. Service Code being requested: H2017 2. Number of Units: _____ 3. Frequency: _____ (weeks)

☐Family Support: _____

1. Service Code being requested: S9482 2. Number of Units: _____ 3. Frequency: _____(weeks)

☐Peer Support: _____

1. Service Code being requested: H0038 2. Number of Units: _____ 3. Frequency: _____(weeks)

☐Community Integration: _____

1. Service Code being requested: H2030 2. Number of Units: _____ 3. Frequency: _____(weeks)

Note: Services below only require authorization from Absolute Total Care, Molina and WellCare.

☐**Individual TX: 1. 90832/90834/90837 2. # of Encounters _____ 3. Frequency: ___weeks**

☐**Family TX: 1. 90846/90847 2. # of Encounters _____ 3. Frequency: _____weeks**

☐**Group TX: 1. 90849/90853 2. # of Encounters _____ 3. Frequency: _____weeks**

Treatment Review
(Complete only when requesting Re-Authorizations)

Number of appointments attended since last authorization: ☐N/A___

Type of Services and Units/Encounter used from last authorization:

☐**Individual TX_____# of Encounters** ☐ **Family TX _____# of Encounters** ☐**Group TX _____# of Encounters**

☐Behavior Modification _____ # of Units ☐ Family Support _____ # of Units ☐ PRS _____# of Units

☐Peer Support Services _____ # of Units ☐ Community Integration Services _____# of Units

Other treating provider Signature:	**Date:**