HEALTH PLANS
UNIVERSITY OF UTAH

SUD Residential Treatment
Request Form January 2020

Substance Use Disorder Residential Treatment Services
Prior Authorization Request Form

1. Today's Date:	**SUBMIT THIS COMPLETED FORM AND ALL REQUIRED SUPPORTING DOCUMENTATION TO:**
2. Original Date of Admission to Treatment Center:	**FAX: (801) 213-2132**
3. Has a previous prior authorization been issued for this admission? ☐ Yes ☐ No If yes, what is the previous prior authorization number? _____ What is the date range on the previous prior authorization? _____- _____	**EMAIL: uuhptransition@hsc.utah.edu** FOR QUESTIONS REGARDING PRIOR AUTHORIZATIONS, PLEASE CALL: (801) 213-4104
4. Requested Dates of Authorization: (date span must match total days requested below): -	
5. Is this a retroactive request? ☐ No ☐ Yes (If yes, reason for retroactive request is required) _____ _____ _____	

Medicaid Member Information

6. Member Name:		**7. Medicaid ID#:**
8. Date of Birth:	**9. Age:**	**10. Gender:** ☐ Male ☐ Female
11. Has Medicaid eligibility been verified? ☐ Yes ☐ No https://medicaid.utah.gov/eligibility	**12. Is the member enrolled in a managed care plan for substance use disorders?** ☐ Yes ☐ No (Requests should be sent to the Health Plan or Network listed under "Substance Use Disorder Provider" on the eligibility lookup tool)	

Servicing Provider Information

13. Provider Name:	**14. Provider NPI #:**	
15. Provider Address: _____ _____ _____	**16. Provider Phone Number:** (___)_____Ext._____ **Office Contact Name:** _____	**17. Provider Fax Number:** (___)_____ **Provider Email:** _____

18. Requested Service

	Total Days Requested
H0018 – (17 or more beds) Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem (Alcohol and/or drug services).	
H2036 – (16 or less beds) Behavioral health; short-term residential (non-hospital residential treatment program), without room and board, per diem (Alcohol and/or drug services).	

19. Comments (Optional)

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Note: Please ensure all required documentation has been submitted with the request (see below for list of required documentation)

INSTRUCTIONS FOR PRIOR AUTHORIZATION REQUEST FORM

ALL BOLDED INFORMATION BELOW MUST BE COMPLETED LEGIBLY AND CORRECT OR THE REQUEST WILL BE RETURNED WITHOUT BEING PROCESSED

1. **Today's Date:** Date of request submission
2. **Date of Admission to Treatment Center:** First date of current admission
3. **Has a previous prior authorization been issued for this admission:** If yes, please provide the previous PA # and the date span of that PA
4. **Requested Dates of Authorization:** Dates requested for this PA. Requested dates should be in alignment with previous PA dates if this is a subsequent authorization. Requested dates of service should also reflect the therapeutic recommendation and submitted clinical documentation.
5. **Is this a retroactive request:** All initial requests must be received within three business days of admission. All Clinical PA (continued stay) Requests must be submitted within five calendar days prior to the end of the initial/previous treatment episode. All reviews received after the last covered day will be subject to retroactive authorization if circumstantial eligibility is determined** See Section 1 of the Medicaid Manual for guidelines pertaining to retroactive prior authorizations
6. **Member Name:** First and Last Name
7. **Utah Medicaid ID #:** 10-digit Medicaid ID #
8. **Member Date of Birth**
9. **Member Age**
10. **Member Gender**
11. **Verification of Medicaid Eligibility:** Requests should only be submitted for members that are eligible during requested dates of service
12. **Enrollment in a Managed Care Plan for Substance Use Disorder:** If a health plan is listed on the eligibility look up tool under Substance Use Disorder Provider, the request must be sent to that health plan
13. **Provider Name**
14. **Provider NPI #**
15. **Provider Address**
16. **Provider Phone Number and Contact Name:** Provide the name, email, and direct number to call if Medicaid has prior authorization questions for the provider
17. **Provider Fax Number:** Required for Medicaid correspondence regarding prior authorization
18. **Total Days Requested:** This number should align with the date span listed in #4. Please designate in the appropriate row if the requested services are for procedural code H0018 or H2036
19. **Comments:** This area can be used for any information that you wish to include

In addition to the prior authorization request form, the following information is required:

Clinical PA Request:

- ASAM assessment
  - Must be completed, with updated ASAM ratings in each dimension, no more than 14 calendar days prior to the requested PA start date (ASAM LOC 3.1 must be completed every 30 days, ASAM LOC 3.5 must be completed every 14 days)
- Updated treatment goals (treatment/service plan)
- Estimated Length of Stay
- Discharge Plan
- Documentation must clearly articulate how the beneficiary meets diagnostic and dimensional admission criteria found in *The ASAM Criteria* book for the requested level of care