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BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

FAX TO: 833-923-0829 TELEPHONE: 844-365-4385

Aetna Better Health of Oklahoma
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Oklahoma City, OK 73116

Telephone Number: 844-365-4385
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Date of Request

Did you know that you can use our provider portal Availity® to submit prior authorization request, upload clinical documentation, check statuses, and make changes to existing requests? Register today at www.Availity.com

SERVICE TYPE:

- ☐ PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING
- ☐ APPLIED BEHAVIOR ANALYSIS (ABA)
- ☐ ELECTROCONVULSIVE THERAPY (ECT)
- ☐ OUTPATIENT TREATMENT REQUEST (OTR)

☐ URGENT – When a non-urgent prior authorization request could seriously jeopardize the life or health of a member. The member's ability to attain, maintain, or regain maximum function or that a delay in treatment would subject the member to severe pain that could not be adequately managed without the care/service requested. Urgent requests will be processed within 24 hours.

☐ NON - URGENT STANDARD – Routine services processed within 72 hours.

Visit our ProPAT search tool to determine if a service requested requires PA https://medicaidportal.aetna.com/propat/Default.aspx. A determination will be communicated to the requesting provider.

COMPLETE SECTIONS 1 -3 IN THEIR ENTIRETY.

SECTION 1 – MEMBER INFORMATION		
1. FIRST NAME	**2. M.I.**	**3. LAST NAME**

4. MEDICAID ID#	**5. DATE OF BIRTH (MMDDYYYY)**	**6. MEMBER PHONE # (xxx-xxx-xxxx)**

7. DOES THE MEMBER HAVE OTHER INSURANCE? (Include Policy Number Below)

SECTION 2 – ORDERING / REFERRING & SERVICING PROVIDER INFORMATION		
8. ORDERING/REFERRING PROVIDER NAME	**9. CONTACT PERSON** (For questions)	
10. TELEPHONE # (xxx-xxx-xxxx)	**11. FAX #** (xxx-xxx-xxxx)	**12. NPI**
13. SERVICING PROVIDER NAME / FACILITY / AGENCY	**14. CONTACT PERSON** (For questions)	
15. TELEPHONE # (xxx-xxx-xxxx)	**16. FAX #** (xxx-xxx-xxxx)	**17. NPI**

SECTION 3 – DIAGNOSIS CODES AND SERVICE / HCPCS CODES	
18. SERVICE START DATE (MMDDYYYY)	**19. SERVICE END DATE** (MMDDYYYY)
20. ICD 10 / DSM 5 CODE(S)	**21. CODE DESCRIPTION(S):** Include description of the service when uncertain of a code

22. CPT / HCPCS / REV CODES WITH MODIFIER(S):	**23. CODE DESCRIPTION(S):**	**24. QUANTITY / UNITS:**

COMPLETE THE SECTION WHICH CORRESPONDS TO THE SERVICE AUTHORIZATION BEING REQUESTED.

NOTE: SECTION 8 "ATTESTATION" MUST BE COMPLETED FOR ALL REQUESTS

SECTION 4 – ECT Complete all fields in their entirety.	
25. TREATMENT REQUEST FOR:	**26. PLACE OF SERVICE** (If inpatient, why?)
Initiate ☐ Concurrent ☐	
27. PRIOR ECT TREATMENT?	**28. INFORMATION CONSENT OBTAINED?** (If applicable)
Yes ☐ No ☐	Yes ☐ No ☐
29. SUBSTANCE ABUSE HISTORY?	**30. ATTENDING PYSCHOTHERAPY?**
Yes ☐ No ☐	Yes ☐ Frequency _____
31. KNOWN SEIZURE HISTORY / CONTRAINDICATIONS TO ECT?	
32. KNOWN REACTION TO ANESTHESIA, OR MEDICAL COMPLICATION TO ECT?	
33. TARGET SYMPTOMS?	
34. AREAS OF CONCERN (Select all that apply)	
☐ Presence of cognitive disorder	☐ Presence of significant personality disorder
☐ Lack of housing or family/social support for transition from IP ECT to OP ECT	

Include the following clinical documentation with the ECT Prior Authorization Request:

- Recent comprehensive Psychiatric Evaluation
- History of Psychiatric Treatment to date (include all levels of care)
  - Include onset, course, and severity of illness
  - Response to treatment
  - Describe Patient's overall treatment compliance
- For prior ECT treatment, include dates, location, number of treatments, results and known contraindications to ECT
- Substance abuse history and current status

- Any labs/diagnostic tests available to the prescribing clinician

SECTION 5 – PSYCHOLOGICAL / NEUROPSYCHOLOGICAL TESTING REQUEST Complete all fields in their entirety.	
35. SERVICE TYPE REQUESTED:	**36. PRIOR TESTING?** (If yes, include date)
Psychological ☐ Neuropsychological ☐	Yes ☐ DATE (MMDDYYYY) _____ No ☐
37. CURRENT BH OUTPATIENT SERVICES?	**38. PSYCHIATRIC DIAGNOSTIC EVALUATION?**
Yes ☐ No ☐	Yes ☐ No ☐
39. WHAT IS THE CLINICAL QUESTION TO BE ANSWERED BY TESTING?	
40. HOW WILL TESTING AFFECT MEMBER'S TREATMENT?	
41. DETAILED CLINICAL SUMMARY FROM TREATING PSYCHIATRIC PROVIDER FOR 6 MONTHS:	

Include the following documentation with the Psychological/Neuropsychological Prior Authorization Request:

- Detailed clinical summary (Physical & Behavioral Health)
- BHMP Evaluation & progress notes that detail assessment of clinical concern
- Any supporting rating scales
- Neurological assessment reviewed by BHMP (if request is for a Neuropsychological Evaluation)
- Any prior testing completed

SECTION 6 – APPLIED BEHAVIORAL ANALYSIS (ABA) Complete all fields in their entirety.	
42. REQUEST TYPE?	**43. TREATMENT SETTING?**
Initial ☐ Concurrent ☐	
44. CLINICAL SYMPTOMS OR SOCIAL BARRIERS?	
45. DISCHARGE PLAN (Anticipated date to transition to lower level of care)	

SECTION 7 – OUTPATIENT TREATMENT REQUEST (OTR) REQUEST

Complete all fields in their entirety.

46. REQUEST TYPE?	**47. SERVICE TYPE?**
Initial ☐ Concurrent ☐	Substance Use Order ☐ Mental Health ☐

48. CLINICAL SYMPTOMS OR SOCIAL BARRIERS?

49. DISCHARGE PLAN (Anticipated date to transition to lower level of care)

50. Substance Abuse and/or Mental Health History – History and Current Status:

51. Criteria / Level of Care Utilized in Past 12 Months:

Criteria/Level of Care	Name of Provider	Duration	Approximate Dates (MMDDYYYY – MMDDYYYY)	Outcome

52. OPTIONAL SPACE FOR ADDITIONAL DOCUMENTATION

Include the following documentation with the ABA Request or OTR Prior Authorization Request:

- Clinical data (Psycho/Social/Behavioral history, mental status, current specific maladaptive behaviors and/or skill deficits, co- occurring disorders, and medical condition(s)
- Progress reducing target behaviors/skill deficits or lack of, and plan to address. For initial ABA requests, include progress or lack- of, with any previous treatment interventions
- Compliance with treatment and treatment recommendations, include plan to address non - compliance
- For ABA Requests, include treatment plan

SECTION 8 – ATTESTATION Complete all fields in their entirety.	
53. Printed Name of Provider/Clinician:	**54. Date (MMDDYYYY):**
55. Signature of Provider/Clinician:	

To prevent delay in processing your request for services, please attach clinical documentation / medical records to support your request. Please include the following: conservative treatment tried without success, applicable diagnostic testing with results, lab values and a medication list. Incomplete requests will delay the prior authorization process.

AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVICE. TO ENSURE PROPER PAYMENT FOR SERVICES RENEDERED; PROVIDER/ FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE