BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

FAX TO: 866-366-7008 TELEPHONE: 844-835-4930

Aetna Better Health of West Virginia
500 Virginia Street East Suite 400
Charleston, WV 25301
Telephone Number: 844-835-4930
TTY: 711

Date of Request (MMDDYYYY):

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 **SECTION 5**
- ☐ APPLIED BEHAVIOR ANALYSIS (ABA) **SECTION 6**
- ☐ ELECTROCONVULSIVE THERAPY (ECT) / TRANSCRANIAL MAGNETIC STIMULATION (TMS) **SECTION 4**
- ☐ OUTPATIENT TREATMENT REQUEST (OTR) **SECTION 7**

☐ **URGENT** – The prior authorization request will be processed within 2 calendar days if the request is for medical care or other services for a condition where application of the time frame for making routine or non-life-threatening care determinations is either of the following: 1) could seriously jeopardize the life, health, or safety of the patient or others due to the patient's psychological state or 2) in the opinion of a health care practitioner with knowledge of the patient's medical condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

☐ **NON - URGENT STANDARD** – Routine services processed within 5 business days.
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.

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Date of Request (MMDDYYYY):

22. CPT / HCPCS / REV CODES:	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 / TMS REQUEST
Complete all fields in their entirety.

25. TREATMENT REQUEST FOR: Initial ☐ Concurrent ☐	26. PLACE OF SERVICE (If inpatient, why?):
27. PRIOR ECT TREATMENT? Yes ☐ No ☐	28. INFORMATION CONSENT OBTAINED? (If applicable): Yes ☐ No ☐
29. SUBSTANCE ABUSE HISTORY? Yes ☐ No ☐	30. ATTENDING PYSCHOTHERAPY? Yes ☐ Frequency: _____ No ☐

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 ☐

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Include the following clinical documentation with the ECT/TMS 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
Psychological ☐ Neuropsychological ☐

36. PRIOR TESTING? (If yes, include date)
Yes ☐ DATE (MMDDYYYY): No ☐

37. CURRENT BH OUTPATIENT SERVICES?
Yes ☐ No ☐

38. PSYCHIATRIC DIAGNOSTIC EVALUATION?
Yes ☐ No ☐

39. WHAT IS THE CLINICAL QUESTION TO BE ANSWERED BY TESTING? HOW WILL TESTING AFFECT MEMBER'S TREATMENT?

40. WHICH TESTING MEASURES ARE BEING GIVEN?

41. DETAILED CLINICAL SUMMARY FROM TREATING BHMP PROVIDER INCLUDING THERAPIST, PSYCHIATRIST, OR OTHER QUALIFIED SPECIALIST:

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?
Initial ☐ Concurrent ☐
If concurrent, how long has member been receiving services?

43. TREATMENT SETTING?

44. CLINICAL SYMPTOMS OR SOCIAL BARRIERS?

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

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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:

NOTE: This form must be completed in its entirety in order to receive a determination. Incomplete forms may lead to delays in processing or lack of authorization.

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.