Prior Authorization Request Form
Nevada Medicaid and Nevada Check Up

Mental Health Request for PHP/IOP Services

(Partial Hospitalization Program and Intensive Outpatient Program)

Purpose: To request mental health services for Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP).

Upload this request through the Provider Web Portal. **Questions? Call:** (800) 525-2395

DATE OF REQUEST:

REQUEST TYPE: ☐ Initial Prior Authorization – Start date of services: _____

☐ Concurrent Authorization

☐ Retrospective Authorization – Date of eligibility Decision:

NOTES:

SECTION I. REQUESTING PROVIDER

Name:		Credentials:
NPI:	Phone:	Fax:
Requesting provider's group NPI:		

Please check one of the following:

☐ Requesting provider is an enrolled hospital or an enrolled Federally Qualified Health Center (FQHC) (that assumes clinical liability and meets the criteria of a Certified Mental Health Clinic) with an enrolled provider type (PT) 14 Specialty 814 Behavioral Health Community Network (BHCN).

☐ Requesting provider is an enrolled PT 14 Specialty 814 BHCN with a contract on file at the Division of Health Care Financing and Policy (DHCFP) to provide PHP in coordination with a hospital or FQHC. Contract information is required to be on file with the DHCFP for the PHP authorization request to be reviewed.

☐ Requesting provider is an enrolled PT 14 Specialty 814 BHCN and has attached the curriculum and schedule for IOP to this authorization request. Curriculum and schedule information is required to be on file with the DHCFP for the IOP authorization to be reviewed.

SECTION II. RECIPIENT

Name:	DOB:
Recipient Medicaid ID:	Age:
Recipient's Living Arrangements (e.g., group home, foster home, parents):	
Is the recipient in State custody? ☐ Yes ☐ No ☐ Unknown	Date recipient went into State custody:

SECTION III. RESPONSIBLE PARTY

Organization/Legally Responsible Adult Name:	Phone:
Relationship to Recipient:	

SECTION IV. ICD-10 DIAGNOSIS

(If using DC:0-3, use the appropriate crosswalk and enter the appropriate ICD-10 diagnosis code and disorder)

Primary Code:	Disorder:
Secondary Code:	Disorder:
Tertiary Code:	Disorder:
Clinical Assessor Name and Credentials:	Date:

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SECTION V. ASSESSMENT SCORE

☐ CASII	Score:	Level:	Date:
☐ LOCUS	Score:	Level:	Date:

☐ ECSII or Other Assessment *(specify):*	Score:	Level:	Date:

Clinical Assessor Name:	Credentials:

SECTION VI. FOR PHP/IOP SERVICES: DETERMINATION OF SEVERELY EMOTIONALLY DISTURBED OR SERIOUSLY MENTALLY ILL

Does recipient have determination of:

Severely Emotionally Disturbed (SED) (Children 17 years of age or younger) ☐ Yes ☐ No

Seriously Mentally Ill (SMI) (Adults 18 years of age or older) ☐ Yes ☐ No

SECTION VII. CURRENT MEDICATIONS

List current medications/dosage. Attach additional sheets if needed to fully document all medications.

Medication Name	Dosage/Frequency
1.	
2.	
3.	
4.	
5.	

SECTION VIII. CURRENT FUNCTIONING AND RISK FACTORS

Describe functioning in various areas (e.g., social, school, relationships) and note any indicators of heightened risk (e.g., abuse, suicide/homicide ideation/attempts, psychosis, medical conditions).

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Physical or sexual abuse or child/elder neglect: ☐ Yes ☐ No

If Yes, patient is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in family

Abuse or neglect involves a child or elder: ☐ Yes ☐ No

Abuse has been legally reported: ☐ Yes ☐ No

SECTION IX. TREATMENT PLAN

Provide goals, interventions, expected outcomes, and time frames.

SECTION X. SIGNIFICANT LIFE EVENTS AND FAMILY HISTORY

Provide significant life events that relate to the recipient's diagnosis and/or that brought the recipient to treatment, e.g., pertinent family information, developmental history, medical issues, sexual history, substance abuse and legal history. Attach additional sheets if needed to fully document significant life events and family history.

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SECTION XI. PREVIOUS TREATMENT *Provide dates of previous treatment.*
☐ Inpatient Psychiatric Dates:
☐ RTC Dates:
☐ Outpatient Mental Health Dates:
☐ Substance Abuse Dates:

Code		**Start Date**	**End Date**	**Units per Day**	**Units per Week**	**Total Units**
	Requested					
Days of the Week Treatment Provided:						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Requester's Signature:						

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.