of Tennessee

COMMERCIAL

Psychiatric Clinical Service Authorization Request Form

☐ Initial Request - Complete all sections for **initial** requests.

☐ Concurrent/Continued Stay Review – Reference/Authorization Number: _____

Inpatient Request

☐ Psych Residential

☐ Psych Acute

Outpatient Request

☐ Psych Partial Hospitalization

☐ Psych Psychiatric Intensive Outpatient Program (IOP)

☐ Other (Specify) _____

Requested Start Date for this authorization: ____ / ____ / ____

Number of Days/Sessions: _____ Frequency Requested: _____

Estimated Discharge Date: ____ / ____ / ____

Member Information

Member Name: _____ Member ID: _____

Date of Birth: ____ / ____ / ____ Member Phone Number: _____

(If applicable) Parent/Guardian Name: _____

DSM-5/ICD-10 Diagnosis Codes: _____

Co-morbidities (medical conditions): _____

Treating Provider and Facility Information

Ordering Physician/Clinician: _____

Provider ID/NPI: _____ Tax ID: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Facility/Group Name: _____ Provider ID/NPI: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax (If different from above): _____

Utilization Review (UR) Information

UR Contact Name: _____ UR Contact Phone: _____

UR Contact Email Address: _____ UR Fax Number: _____

Clinical Information (if concurrent review please see section below)

Date of evaluation/assessment: _____ / _____ / _____

Previous Treatment History:

Presenting Problem (description of acuity, presenting symptoms, nature of suicide attempts or aggression, need for medical attention for members or others, maladaptive behaviors):

Precipitant (stressors, triggers for behaviors, frequency, date of last occurrence):

Symptoms related to diagnosis:

Danger to Self or Others:

Suicidal Ideation: ☐ Yes ☐ No

Plan: _____

Intent: _____

Means: _____

Homicidal Ideation: ☐ Yes ☐ No

Intended Victim: _____ Victim Notified? ☐ Yes ☐ No

If no, why not? _____

Means/Access: _____

History of attempts/aggression (dates if known): _____

Psychosis: ☐ Yes ☐ No

If yes, describe delusions, hallucinations, command hallucinations and/or thought disorder.
If first episode, have neurological causes been ruled out?

Baseline: _____ UDS/BAL: _____

MSE: _____

Other behaviors that constitute risk to self or others:

Complete sections marked with an asterisk * for concurrent requests.

Psychosocial Factors (home environment, family/social support, family issues, history of abuse/trauma, occupational/school problems, legal/social service involvement, current/history of substance abuse, UDS results):

*Medications (name, dosage, frequency):

*Medication Compliant? ☐ Yes ☐ No Barriers?_____

Treatment Plan/Goals:

*Discharge Plan (stepdown plan and disposition):

Concurrent Review Date: _____ / _____ / _____

(i.e. updated MSE, barriers to discharge, pertinent clinical information, justification for continued stay, individual, family, and group session):

*Medications (name, dosage, frequency):

*If no progress toward stabilization and discharge readiness behavior, how will the treatment plan be changed?

*Discharge Plan (step down plan and disposition):

*Discharge Readiness Behavior? _____

*What progress has been made toward stabilization and discharge readiness since last review?

Include additional information below or attach additional clinical to fax:

By submitting this request, you're confirming that you've provided all clinical information available pertinent to this request and you're requesting the decision be made based on information provided in your submission.

Please complete this form and submit it as an attachment through one of the following options.
Tennessee providers may submit authorization requests at any time in Availity®. Out-of-state providers may submit authorization requests through their provider portal or Cohere®. If you have questions about submitting a prior authorization request, please call **(423) 535-5717**, **option 2**, or contact your eBusiness Network Manager.

26PED4051800 (03/26)