of Tennessee

COMMERCIAL

Substance Use Disorder (SUD) Clinical Service Authorization Request Form

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

☐ **Concurrent/Continued Stay Review – Reference/Authorization #** _____

Complete sections marked with an asterisk for concurrent requests.*

☐ SUD Residential

☐ Inpatient Detox ASAM 4.0

☐ SUD Residential Detox 3.7

☐ SUD Outpatient Request

☐ SUD Partial Hospitalization

☐ SUD IOP

☐ Other (Specify) _____

Requested Start Date for this authorization: _____

*Number of Days/Session: _____ Frequency Requested: _____

Estimated Discharge Date: _____

Did the member seek treatment at the Emergency Room prior to this admission? ☐ Yes ☐ No

If yes, name of hospital: _____

Member Information

Member Name: _____ Member ID#: _____

Date of Birth: _____ Member Phone: _____

Parent/Guardian Name (if applicable): _____

DSM-5/ICD-10 Diagnosis Codes: _____

Co-morbidities (medical conditions): _____

Continued on next page

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: _____ Tax ID: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____

Utilization Review (UR) Contact: _____

UR Contact Phone: _____ UR Fax: _____

Clinical Information (if for concurrent review, please see section below)**:**

Date of evaluation/assessment: _____

Presenting Problem:

Substance Use Disorder History: (drugs of choice, amounts, route of administration, frequency of use, age of first use, date of last use)

Mental Status Exam and motivation for seeking treatment:

Continued on next page

*__Vitals:__

Date of Vitals: _____ Blood Pressure: _____ Pulse: _____

Temperature: _____ Respirations: _____

CIWA Score: _____ COWS Score: _____

*Withdrawal Symptoms: _____

*UDS/BAL date/results: _____

Psychosocial Factors (home environment, family/social support, family issues, history of abuse/trauma, occupational/school problems, social service involvement, current/history of mental health issues, medical and legal consequences.):

Treatment History (including family involvement in treatment, previous attempts in treatment/outcomes):

*Treatment Plan/Goals:

Sponsor in place? ☐ Yes ☐ No

If yes, name of sponsor: _____

*Medications (name, dosage, frequency):

*Medication Compliant? ☐ Yes ☐ No Barriers? _____

Has Medication Assisted Treatment been considered? ☐ Yes ☐ No

If yes, explain:

Continued on next page

Concurrent Review Date (Complete sections marked with * for concurrent requests.): _____
(i.e. updated MSE, barriers to discharge, pertinent clinical information, justification for continued stay, vitals, COWS, CIWA, UDS, withdrawal symptoms)

*Medications (name, dosage, frequency, date added/changed):

*If no progress, what are the updates to the treatment plan?

*Discharge Plan (step down and disposition):

Other relevant information:

Estimated length of stay, duration of service: _____

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.

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.