# Inpatient Psychiatric Admission Prior Authorization Request Form

Complete and fax all requested information below including any supporting documentation as applicable to Highmark Health Options at **1-855-412-7997. Authorization is based on medical necessity. Incomplete information or illegible forms will delay processing.**

**Questions or concerns?** Call Utilization Management at 1-844-325-6251, Monday through Friday, 8 a.m. to 5 p.m.

**Date:** ____________________

| **Member Information** | | |
|---|---|---|
| **Member Name** | **Member ID** | **Date of Birth** |
| **Diagnosis** | **ICD-10 Code** | |

| **Provider Information** | |
|---|---|
| **Facility Name** | **NPI Number** |
| **Facility Address** | |
| **Provider Name** | **Provider NPI Number** |
| **Provider Phone** | **Provider Fax** |
| **Contact Person Completing Form** | **Contact Phone** |
| **Contact Person at Facility** | **Contact Fax** |
| **Date of Admission or Start of Care Under Current Plan** | |
| **Admitting Physician** | |

| **Admission Status** | |
|---|---|
| ☐ **Voluntary** | ☐ **Involuntary** |

| **Type of Request** | |
|---|---|
| ☐ **Admission** | ☐ **Continued Stay** |
| **Is this a readmission?** ☐ Yes ☐ No | |
| **Is the member under the influence of drugs or alcohol at the time of admission?** ☐ Yes ☐ No | |

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| Can the member be safely maintained at a lower level of care? ☐ Yes ☐ No |
|---|
| **Provide justification.** |
| **Does the member have any known legal issues (e.g., outstanding warrants, probation/parole, mental health/drug court, court mandating)?** ☐ Yes ☐ No |

| Initial Request Information |
|---|
| **Describe presenting symptoms and problems.** |
| **List all diagnoses and conditions.** |

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## Continued Stay Request

**Any changes in mental status, symptoms, or behavior since last review?** ☐ Yes ☐ No

**List changes in diagnoses.**

## Current Medications

| Medication | Dosage | Frequency | Medication Changes Since Last Review | Date of Change |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## List Any PRN Medications Given Since Last Review

| Medication | Dosage | Frequency | Date Given |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Care of Outpatient Provider

**Was the member under the care of an outpatient provider prior to time of admission?** ☐ Yes ☐ No ☐ Unknown

| Provider(s) Name | Provider(s) Phone |
|---|---|
| | |

## Case Manager/ACT Team

**Does the member have a Case/Manager/ACT team?** ☐ Yes ☐ No

**Was the notification made?** ☐ Yes ☐ No

| Provider(s) Name | Provider(s) Phone |
|---|---|
| | |

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## Substance Use

**Any substance use issues?** ☐ Yes ☐ No

**Describe substance use history. Include amount, duration, frequency, last use, etc.**

## Mental Status and Compliance with Treatment

**Provide details about the member's baseline mental status and compliance with treatment?**

## Support System

**Does the member have family/informal supports (e.g., friends, significant other, partner, spouse, family, or other natural or professional supports) upon discharge who are able to help the member maintain behavioral wellness?**

☐ Yes ☐ No ☐ Unknown

**Provide a list of family/informal supports. Include contact information, address, and phone of member discharge location. Share any other information that will help member outreach.**

## Treatment Plan

**Describe treatment plan and orders with admission.**

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## Discharge and Aftercare Plan

**Describe discharge and aftercare plan. Include post-discharge living arrangements.**

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