Outpatient Behavioral Health 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	
☐ **In-network Provider**	☐ **Out-of-Network Provider**
If Out-of-Network, does the member have a prior or existing treatment relationship with the provider? ☐ Yes ☐ No	
Provide summary of member's treatment relationship with provider. Include why member's care cannot be met by an in-network provider.	

Type of Outpatient Request			
☐ **Mental Health**	☐ **Substance Abuse**	☐ **Continued Stay**	☐ **Step Down**

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Clinical Information

Describe presenting symptoms and problems.

List all diagnoses and conditions. Include diagnosis codes.

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HIGHMARK HEALTH OPTIONS

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Current Medications (Attach supplemental sheet if necessary)		
Medication	**Dosage**	**Frequency**

Type of Outpatient Service Requested

Complete only for the requested service and appropriate service line.

Discharge Planning and Transition to Lower Level of Care

Describe discharge planning and transition plan.

Can the member be managed at a lower level of care? ☐ Yes ☐ No
Provide justification.

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Current Case Management Needs
Describe current case management needs.

Mental Health Services

Complete this section if requesting mental health services.

Partial Hospitalization (PHP)	
Number of Days Per Week	Hours Per Day

Intensive Outpatient (IOP)	
Number of Days Per Week	Hours Per Day

Psychological Testing	
CPT Code(s)	Number of Hours

Outpatient ECT	
Number of Sessions	Frequency

Non-Par Authorization Request	
CPT Code(s) Requested	Frequency

ABA Therapy	
Number of Sessions	Frequency

Substance Use Services

Complete this section if requesting substance use services.

Partial Hospitalization (PHP)	
Number of Days Per Week	Hours Per Day

Intensive Outpatient (IOP)	
Number of Days Per Week	Hours Per Day

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Halfway House	
Number of Days	**Number of Hours**

Non-Par Outpatient	
CPT Codes Requested	**Frequency**

Substance Use and Treatment History
Any substance use issues? ☐ Yes ☐ No
If yes, describe substance use history. Include amount, duration, frequency, last use, etc.
If yes, describe current withdrawal symptoms.
If yes, describe treatment history. Provide longest clean time and other details.

ASAM Criteri		
Level of Care	**Risk Level**	**Criteria Indicated**
Dimension I:		
Dimension II:		

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Dimension III:		
Dimension IV:		
Dimension V:		
Dimension VI:		

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