

Prior Authorization Request for Continuation of Mental Health and Chemical Dependency Services

Instructions for completing the Prior Authorization Request for Continuation of Mental Health and Chemical Dependency Services.

Prior authorization is required for the continuation of mental health/chemical dependency services. Please reference the bottom portion of the Initial Authorization Request for Mental Health and Chemical Dependency Services form on page 1. It indicates how many visits were initially approved. If the initial visits that were approved have been exhausted, this form needs to be completed. Failure to submit the completed form to the Health Plan will result in denial of any further services beyond what was initially approved.

1. Complete the top portion of page 1, which includes patient and provider information.
2. Complete all requested information on page 2. Failure to provide the requested information will delay the processing of the authorization form. We will gladly accept any other documents or formats that include all the requested information on page 2.
3. Fax the completed form to the **confidential fax number** listed on the top of page 1.
4. After the Health Plan receives, reviews all necessary information and determines medical necessity, the first page of the form will be faxed to you indicating what services have been authorized.

Reminder: Day treatment, structured outpatient programs (transitional care) and group therapy require prior authorization.

**Health Tradition
 Managed Care Department
 P. O. Box 188
 La Crosse, WI 54602**

**Please complete form and fax to:
 Attn: Mental Health Services
 Fax Number: 608-781-9654
 Telephone Number: 608-781-3208 (La Crosse Area)
 1-800-658-9006 (Toll Free)**

*Prior Authorization Request for **Continuation** of Mental Health and Chemical Dependency Services*

Please **print** clearly. Inability to read this form may delay processing.
Completion of this form does not imply authorization of care or provision of plan benefits.

Date _____/_____/_____

Patient Name: _____ DOB: _____/_____/_____

Insurance Number: _____ Insurance: _____

Clinician Name: _____ Facility Name: _____

Telephone Number: _____ Fax Number: _____

Type of Service: Individual/Family Group

For Health Tradition Use Only

Reference Number: _____ Entered Data Base: _____
 Ucare Authorization: _____
 MHS Authorization: _____

Review Date: _____ Care Manager: _____

	Number of Sessions Approved Including Dates of Service	Denied
Individual/Family		
Group		

Comments: _____

Date Faxed To Provider: _____

DSM-IV Diagnosis (may attach treatment plan):

Axis I _____ Axis II _____ Axis III _____

Axis IV _____ Axis V Current _____

Highest in the Past Year _____

Changes in Medications Since Last Report

None

Name	Date Started	Prescribing Practitioner

Describe current and continued symptoms since last request:

Treatment Goals (May attach a copy of the Treatment Plan)

Indicate progress towards previous goals, include improvements in symptoms and effectiveness of current treatment.

If there has been no progress, what are the barriers and the plan to address these?

Dates of Sessions Used (this calendar year): _____

Medication Management: _____

Anticipated length of treatment: _____