

# Initial Authorization Request for Mental Health/Chemical Dependency Services

Instructions for completing the Initial Authorization Request for Mental Health and Chemical Dependency Services.

The first 15 individual visits per calendar year do not require any authorization or notification to the Plan. Prior authorization of services beyond the 15th visit is required and depends on medical necessity being demonstrated. Failure to complete the form and receive authorization from the Plan, will result in denial of services.

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 **Initial** 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

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**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:

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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 \_\_\_\_\_

List current symptoms that support the DSM diagnosis and indicate duration/onset of symptoms:

Current Medications

None

Name	Date Started	Prescribing Practitioner

**Psychiatric Hx:** Indicate any history of mental health or substance abuse treatment. Specify if it was inpatient or outpatient treatment including length/duration and outcome of the treatment.

**For substance abuse include current and past drugs used and pattern of use (may attach a copy of initial assessment):**

**Treatment Goals:** Indicate targeted and measurable goals, including expected date of completion for each goal (may attach treatment plan).

Medication Management: \_\_\_\_\_

Anticipated length of treatment: \_\_\_\_\_

**What date(s) in this calendar year have you seen this patient:** \_\_\_\_\_

\_\_\_\_\_