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Prior Authorization Request for CHEMICAL DEPENDENCY TREATMENT

☐ PRIOR AUTHORIZATION REVIEW ☐ RETROSPECTIVE REVIEW

MEMBER INFORMATON:

Patient Name:	Patient Member Number:	Date of Birth: **(MM/DD/YYYY)**
Patient Gender: ☐ M ☐ F	Phone Number:	UHA Plan: ☐ 600 ☐ 3000
Other Insurance? ☐ Yes ☐ No	Specify Other Insurance:	Subscriber:

2) REQUESTING PHYSICIAN / PROVIDER INFORMATION:

Name: Specialty:	TAX ID# (**Out of State Providers ONLY)**
Contact Person:	Phone: Fax:
Address:	
Referring Provider:	Phone: Fax:
Personal Care Physician:	Phone: Fax:

3) SERVICING PROVIDER / PROGRAM INFORMATION:

Facility / Program Name:	Contact Person:
Address:	Phone: Fax:
Medical Director:	Phone: Fax:
Levels of Care Available at this Facility / Program: ☐ Detox ☐ Residential ☐ PHP ☐ IOP	Facility TIN: Accreditation: ☐ JCAHO ☐ CARF ☐ None ☐ Other

4) CLINICAL INFORMATION:

Requested Level of Care: (all service levels are per diem)	**List Revenue code:**	**List Estimated Dates of Service:**
☐ Medical Detoxification Treatment ☐ ASAM 4.0	☐ RC	to
☐ Subacute Detoxification Treatment ☐ ASAM 3.7	☐ RC 0126	to
☐ Residential Treatment ☐ ASAM 3.5 ☐ ASAM 3.3 or 3.1	☐ RC 1002 ☐ RC 0945	**to**
☐ PHP Treatment	☐ RC 0912 ☐ RC 0913	**to**
☐ IOP Treatment	☐ RC 0906	**to**
☐ IOP Treatment with methadone (CHAMP Clinic use only)	☐ HCPCS G2067	**to**

Diagnosis Description:	ICD Code:
Diagnosis Description:	ICD Code:
Diagnosis Description:	ICD Code:

5) ☐ IV DRUG USE ☐ PREGNANT &/OR NURSING Please indicate current drug usage:

6) Previous CD Treatment: ☐ No ☐ Yes (please complete below and include all levels of care received)

a. Facility Name:	Date of Services:	LOC:	Date relapse:
b. Facility Name:	Date of Services:	LOC:	Date relapse:
c. Facility Name:	Date of Services:	LOC:	Date relapse:
d. Facility Name:	Date of Services:	LOC:	Date relapse:
e. Facility Name	Date of Services:	LOC:	Date relapse:
f. Facility Name	Date of Services:	LOC:	Date relapse:

HCR-0536-101821

Please forward the following clinical records with this PA request to include:

- Medical History & Physical
- Intake Assessment including phone interview
- Treatment Plan including updates
- All Progress Notes (medical, therapist, group, nursing, social work)
- Medication List (ordered & administered)
- Vital Signs (including CIWA scores) COWS
- Laboratory Results
- ASAM Dimensions
- Referral Source
- Discharge Plan with estimated length of stay

NOTE: All services outside the State of Hawaii does require a prior authorization

If member was admitted to your facility prior to UHA's receipt of this PA Request, this is considered a Retrospective Review

I HAVE READ THE PAYMENT POLICY ON RESIDENTIAL TREATMENT FOR CHEMICAL DEPENDENCE AND ATTACHED ALL RELEVANT DOCUMENTATION. ☐ **Yes** ☐ **No**

SUBMIT THIS SIGNED AND COMPLETED FORM ALONG WITH SUPPORTING CLINICAL DOCUMENTATION

Failure to submit all relevant clinical documentation will result in delay and possible denial of authorization

Physician Acknowledgment:
I have read and understand the definition of Medical Necessity outlined in Hawaii Revised Statutes 432E-1.4. (see back of sheet). I further understand that UHA applies this definition to the authorization and payment for all services rendered to its members. I, or my agent acting on my behalf, attest that the services requested above meet the definition of medical necessity.

______________________________________ ________________________
Signature of Physician or Agent **REQUIRED** Date