

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:
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SECTION II — GENERAL INFORMATION

Review Type: <input type="checkbox"/> Non-Urgent <input type="checkbox"/> Urgent	Clinical Reason for Urgency:
Request Type: <input type="checkbox"/> Initial Request <input type="checkbox"/> Extension/Renewal/Amendment	Prev. Auth. #:

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
			<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
Subscriber Name (if different):	Member or Medicaid ID #:	Group #:		

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name:		Name:	
NPI #:	Specialty:	NPI #:	Specialty:
Phone:	Fax:	Phone:	Fax:
Contact Name:	Phone:	Primary Care Provider Name (see instructions):	
Requesting Provider's Signature and Date (if required):		Phone:	Fax:

SECTION V — SERVICES REQUESTED (WITH CPT, CDT, OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	Diagnosis Description (ICD version___)	Code

<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Provider Office <input type="checkbox"/> Observation <input type="checkbox"/> Home <input type="checkbox"/> Day Surgery <input type="checkbox"/> Other: _____
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> Mental Health/Substance Abuse Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> Home Health (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Nursing Assessment Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____
<input type="checkbox"/> DME (MD Signed Order Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) (Medicaid Only: Title 19 Certification Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No) Equipment/Supplies (include any HCPCS Codes): _____ Duration: _____

SECTION VI — CLINICAL DOCUMENTATION (SEE INSTRUCTIONS PAGE, SECTION VI)

An issuer needing more information may call the requesting provider directly at: _____

El Paso First Health Plans-Request for Behavioral Health Services

Member's Name: _____ Member I.D. _____

Section VII. Identifying Information:

Current Living Situation:	<input type="checkbox"/> With Parent(s)	<input type="checkbox"/> Group/Foster Home	<input type="checkbox"/> Other (list):
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Section VIII. Court Ordered Service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Section IX. DFPS Directed Service:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Section X. Psychiatric Medications:

Medication	Dose	Frequency	Prescribing Physician

Section XI. Continuation of Therapy Requests: Please indicate the following. (Complete all sections):

Current Symptoms:			
Response to Past Treatment: (Provide Detailed Information)			
Specific Therapeutic Interventions:			
For MHR/TCM Requests Only:	<input type="checkbox"/> Deviation of LOC	<input type="checkbox"/> Reduction of LOC	
Please list reason for Deviation and/or Reduction of LOC (MHR/TCM Only):			

Section XII. Short Term Measurable Treatment Goals: (Note specific progress for each goal)

Goal	Current Progress	Target Date

El Paso First Health Plans-Request for Behavioral Health Services

Member's
Name: _____

Member I.D. _____

Section XIII.

Anxiety/Phobia	Risk Factors	Sleep Patterns	Eating Patterns	Substance Abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Hypersomnia	<input type="checkbox"/> Increase Appetite	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Panic Attack	<input type="checkbox"/> Impaired Judgment	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Decrease Appetite	<input type="checkbox"/> Drugs
<input type="checkbox"/> Phobic Responses	<input type="checkbox"/> Aggression	<input type="checkbox"/> Nightmares	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Active
<input type="checkbox"/> Excessive Worry	<input type="checkbox"/> Oppositional/Defiant	<input type="checkbox"/> Traumatic Dreams	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Remission
<input type="checkbox"/> PTSD	<input type="checkbox"/> Self injurious	<input type="checkbox"/> Hyposomnia		<input type="checkbox"/> Withdrawal Symptoms

Mood	Cognition	Thought Content	Functionality	Activity
<input type="checkbox"/> Anger	<input type="checkbox"/> Decrease Concentration	<input type="checkbox"/> Flight of Ideas	<input type="checkbox"/> Obsessions/Compulsions	<input type="checkbox"/> Decrease in Energy
<input type="checkbox"/> Apathy	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Loose Association	<input type="checkbox"/> Hypersexual	<input type="checkbox"/> Psychomotor Retardation
<input type="checkbox"/> Blunted/Flat Affect	<input type="checkbox"/> Impaired Abstract Thinking	<input type="checkbox"/> Hyper-talkative	<input type="checkbox"/> Impaired ability to function at:	<input type="checkbox"/> Restlessness
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Home	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Elevated/Expansive	<input type="checkbox"/> Difficulty Making Decisions	<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> School	<input type="checkbox"/> Impulsiveness
<input type="checkbox"/> Grandiosity	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	<input type="checkbox"/> Work	
<input type="checkbox"/> Hopelessness		<input type="checkbox"/> Grandiosity	<input type="checkbox"/> High Risk Behavior	
<input type="checkbox"/> Irritable		<input type="checkbox"/> Paranoid Ideation	<input type="checkbox"/> Anti-Social Behavior	
<input type="checkbox"/> Low Self Esteem				
<input type="checkbox"/> Tearfulness				
<input type="checkbox"/> Mood Swings				

Section XIV.

Suicidal: Yes No Explain: _____

Homicidal: Yes No Explain: _____

Emotional Trauma: Yes No Explain: _____

Sexual Trauma: Yes No Explain: _____

Physical Trauma: Yes No Explain: _____