EL PASO FIRST
Health Plans, inc.

Memo

To: Our Valued Providers

From: El Paso First Health Plans

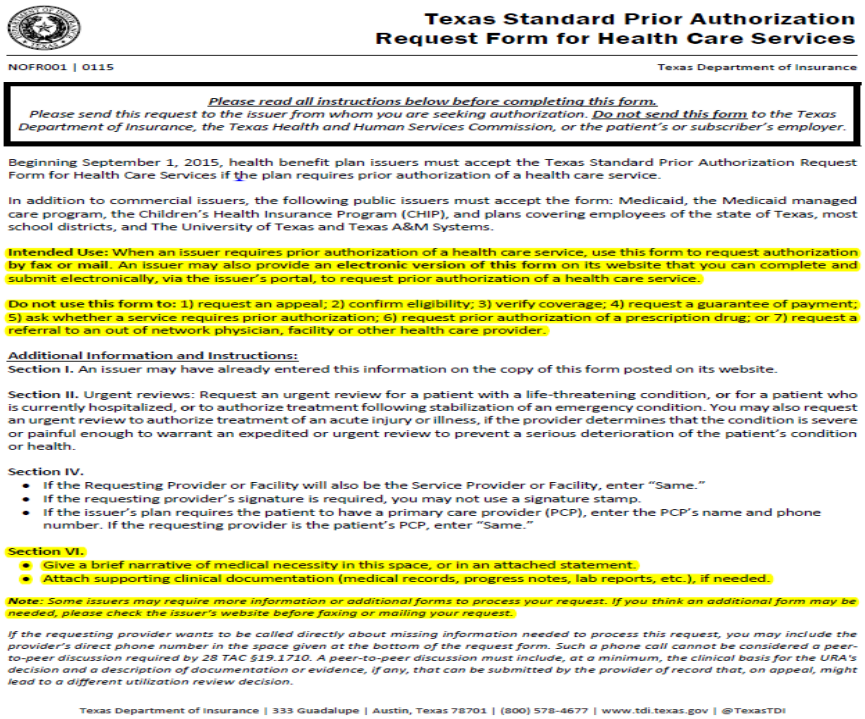
Date: 8/31/2015

Re: New Texas Standard Prior Authorization (PA) Form

Effective 9/1/2015 Texas Standard PA Request Form may be submitted for all Health Care Services.

El Paso First Behavioral Health Providers - In addition to the Texas Standard PA Request Form two additional forms are necessary in order to complete your request for Behavioral Health Services (see below attachments).

The new PA form(s) and instruction sheet is available on our website at http://www.epfirst.com/providers/provider-forms/#2



Texas Standard Prior Authorization Request Form for Health Care Services

NOFR001 | 0115 Texas Department of Insurance

Please read all instructions below before completing this form.
Please send this request to the issuer from whom you are seeking authorization. Do not send this form to the Texas Department of Insurance, the Texas Health and Human Services Commission, or the patient's or subscriber's employer.

Beginning September 1, 2015, health benefit plan issuers must accept the Texas Standard Prior Authorization Request Form for Health Care Services if the plan requires prior authorization of a health care service.

In addition to commercial issuers, the following public issuers must accept the form: Medicaid, the Medicaid managed care program, the Children's Health Insurance Program (CHIP), and plans covering employees of the state of Texas, most school districts, and The University of Texas and Texas A&M Systems.

Intended Use: When an issuer requires prior authorization of a health care service, use this form to request authorization by fax or mail. An issuer may also provide an electronic version of this form on its website that you can complete and submit electronically, via the issuer's portal, to request prior authorization of a health care service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; or 7) request a referral to an out of network physician, facility or other health care provider.

Additional Information and Instructions:
Section I. An issuer may have already entered this information on the copy of this form posted on its website.

Section II. Urgent reviews: Request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV.
- If the Requesting Provider or Facility will also be the Service Provider or Facility, enter "Same."
- If the requesting provider's signature is required, you may not use a signature stamp.
- If the issuer's plan requires the patient to have a primary care provider (PCP), enter the PCP's name and phone number. If the requesting provider is the patient's PCP, enter "Same."

Section VI.
- Give a brief narrative of medical necessity in this space, or in an attached statement.
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

***Note**: Some issuers may require more information or additional forms to process your request. If you think an additional form may be needed, please check the issuer's website before faxing or mailing your request.*

If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion required by 28 TAC §19.1710. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.

Texas Department of Insurance | 333 Guadalupe | Austin, Texas 78701 | (800) 578-4677 | www.tdi.texas.gov | @TexasTDI

Instruction Sheet

(All Providers) New Texas Standardized PA Form Page 1

TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

SECTION I — SUBMISSION

Issuer Name: ABC Managed Care Organization	Phone: 512-888-8888	Fax: 512-999-9999	Date: 6-8-2015

SECTION II — GENERAL INFORMATION

Review Type: ☐ Non-Urgent ☐ Urgent	Clinical Reason for Urgency:
Request Type: ☒ Initial Request ☐ Extension/Renewal/Amendment	Prev. Auth. #: 1212-5656

SECTION III — PATIENT INFORMATION

Name: John Doe	Phone: 512-555-1212	DOB: 7-18-1976	Sex: ☒ Male ☐ Female ☐ Unknown
Subscriber Name (if different):	Member or Medicaid ID #: 123456789	Group #:	

SECTION IV — PROVIDER INFORMATION

Requesting Provider or Facility		Service Provider or Facility	
Name: AAA Community Center		Name: Targeted C. Manager	
NPI #: 1023456789	Specialty: Behavioral Health	NPI #: 9912345678	Specialty: Behavioral Health
Phone: 512-555-4567	Fax: 512-555-6789	Phone: 512-787-7878	Fax: 512-898-8989
Contact Name: Jacob Smith	Phone: 512-555-4578	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
LOC 3		6/5/2015	12/5/2015	Bipolar I Disorder	F31.73

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☒ Other: H0850

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Cardiac Rehab ☒ Mental Health/Substance Abuse

Number of Sessions: _____ Duration: _____ Frequency: _____ Other: _____

☐ Home Health (MD Signed Order Attached? ☐ Yes ☐ No) (Nursing Assessment Attached? ☐ Yes ☐ No)

Number of Visits: _____ Duration: _____ Frequency: _____ Other: _____

☐ DME (MD Signed Order Attached? ☐ Yes ☐ No) *(Medicaid only:* Title 19 Certification Attached? ☐ Yes ☐ No)

Equipment/Supplies (include any HCPCS codes): _____ Duration: _____

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

In the space provided or on a separate page:
- Provide pertinent clinical information to justify requests for initial or ongoing therapy, or increase
- Attach supporting clinical documentation (medical records, progress notes, lab reports, etc.), if needed.

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

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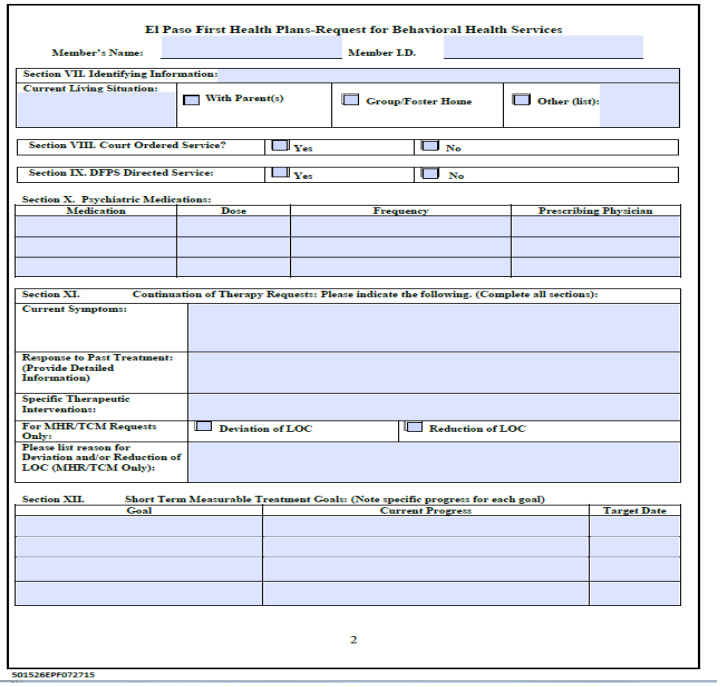
Behavioral Health Services Additional Forms Page 2 and 3



El Paso First Health Plans-Request for Behavioral Health Services

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

Section VII. Identifying Information:

Current Living Situation: ☐ With Parent(s) ☐ Group/Foster Home ☐ Other (list): _____

Section VIII. Court Ordered Service? ☐ Yes ☐ No

Section IX. DFPS Directed Service: ☐ Yes ☐ No

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:	☐ Deviation of LOC	☐ 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

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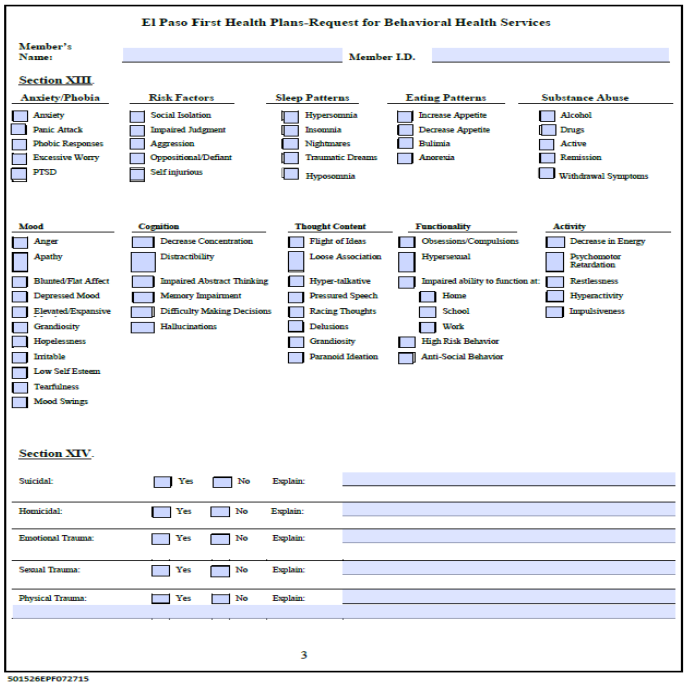

El Paso First Health Plans-Request for Behavioral Health Services

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

Section XIII.

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

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

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If you have questions or concerns regarding the Prior Authorization Form please contact the following departments for assistance at 915-532-3778:
Health Services Department at x1500 or
Provider Relations at x1507.