BENEFICIARY REQUEST FOR SERVICE AUTHORIZATION

Section 1: Completed by client's SCBH Personal Service Coordinator, or SCBH Contractor
Section 2: Completed by SCBH Program Manager
Section 3: Administrative Use only – completed by Section Manager and QAPI staff

SECTION 1: PROVIDE COMPLETE INFORMATION IN ALL SECTIONS

Client Information

Date of Service Request (date requested by client, client's legal representative, or provider):

Case Manager Name (First & Last): Phone Number:
Program Manager Name (First & Last):
Insurance Type (check all that apply): ☐ Medi-Cal ☐ Medi-Care ☐ Other (list):

Client Name: Client Medical Record Number:
Client Age: Diagnosis (current):
Name and Relationship of Person making the request:
Service being requested and why (from requester's perspective):

Service Details

1. Recommended Type of Service*:
2. Proposed frequency:
3. Proposed duration:
4. Contact information for the Requested Service Provider (mailing address, phone number, and e-mail address):

   a. Is the client currently receiving services from the Requested Service Provider?
      ☐ NO - ☐ YES (describe):
   b. If YES, list the dates of attempted contacts made by SCBH staff to verify the existing relationship (at least 3 calls within 10 calendar days)**:
      1) ; 2) ; and 3)
      Existing Relationship Verified: ☐ NO - ☐ YES (attached received clinical documentation)
   c. Indicate the urgency of the service need based on level of risk
      ☐ Standard (within 30 days) ☐ Immediate (within 15 days) ☐ Urgent (within 3 days)
5. **In Section 2 of this form, SCBH Program/Section Managers will select corresponding service codes for recommended services.**
   **** Forward form to SCBH Program once relationship is verified, or after 3 attempts have been made to verify the relationship. Contractors are not responsible for verifying the Existing Provider Relationship and shall forward the BRS to SCBH Program/Section Manager for this purpose.**

Clinical Rationale In Support of the Service Authorization

1. Associated Impairments:

2. Treatment Team's Input:

3. Current/Requested Service Provider's Input

Clinical Documentation In Support of Service Authorization (attach to e-mailed request)

1. Is it in the Assessment? ☐NO - ☐ YES (describe):

2. Is it in the Client Plan? ☐NO - ☐ YES (describe):

SECTION 2: CHECK ALL CODES THAT APPLY

☐301 - Targeted Case Management

☐303 - Intensive Care Coordination

☐310 - Collateral Group

☐311 - Collateral Individual

☐331 - Assessment

☐345 - TBS

☐341 - Individual Therapy

☐351 - Group Therapy

☐316 - Family Therapy

☐371 - Crisis Intervention

☐391 - Plan Development

☐511 - Rehabilitation Individual

☐514 - Rehabilitation Group

☐361 - Medication Support Contractor

☐363 - Medication Support Telehealth

☐365 - Medication Injections

☐361nonEM - Non E&M Medication Support

☐361N1-5, 361NT - E&M Medication Support New Client

☐361E1-5, 361ET - E&M Medication Support Established Client

NOTE: This request for service must be reviewed and approved by a program or section manager prior to submitting the request to the Behavioral Health Plan Administration Committee for consideration.

Manager Name (Print):

Section Manager Name (Print):

Manager Signature:

Section Manager Signature:

Date Reviewed:

Date Reviewed:

SECTION 3: ADMINISTRATIVE REVIEW/RECOMMENDATION

Youth: ☐YES ☐NO COC: ☐YES ☐NO Provider Billing Medi-Cal: ☐YES ☐NO

Beacon Provider: ☐YES ☐NO Beacon Accepted: ☐YES ☐NO

Date of Sect. Mgr. Review:

Sect. Mgr. Recommendation : ☐ APPROVE ☐ DENY ☐ MODIFY

Rationale:

Date of Senior Leadership Review:

Senior Leadership Decision: ☐ APPROVE ☐ DENY ☐ MODIFY

Rationale: