Outpatient Request for Prior Authorization

Member Name:
Provider Number:
Date Completed:

Oklahoma Health Care Authority
2401 NW 23rd St, Suite 1A
Oklahoma City, OK 73107
800-522-0114 (Main) / 405-702-9080 (Fax)

Rev. 04-20-08

Fax Date: _____

Organization _____

Provider ID number _____

Requesting Staff _____

Phone Number _____ Fax # _____

Authorization Type
_____Prior Authorization-Initial
_____Prior Authorization-Extension
_____Courtesy Review/Pending Eligibility

Start date for this request _____

Review Type
_____Outpatient - Behavioral Health
_____Outpatient - Substance Abuse/Integrated
_____Case Management only
_____Psychological Evaluation
_____Modification Request
_____Important Notice Response
_____Other_____

Consumer Information

SoonerCare ID # _____

Social Security # _____

Date of Birth _____

Last Name _____

First Name _____

Middle Initial _____ Designation (Sr., Jr., III, etc.) _____

Current Residence
_____Nursing Home
_____Therapeutic Foster Care (TFC)
_____Group Home - Level _____
_____ICF/MR

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DHS Custody ☐ OJA Custody ☐

Admit date to current facility

Diagnosis (ICD-9-CM)

Axis I	Code		Title	
Axis I	Code		Title	
Axis I	Code		Title	
Axis II	Code		Title	
Axis II	Code		Title	

Axis III

Axis IV

Psychosocial Stressor	None/NA	Mild	Moderate	Severe
Problems related to Primary Support			☐	
Problems in Friendship/Social Relations			☐	
Legal Issues			☐	
School/Work Problems			☐ ☐	
Custody/Placement Issues			☐	
Financial Difficulties			☐	
Problems in Living Situation			☐	
Physical Health				
Access to Health Care Services			☐	
Other:_____				

Axis V Current ☐ Highest level in the last year ☐

Since last authorization request, GAF score has

☐ Increased
☐ Decreased
☐ Not Changed
☐ Unknown/Not Applicable

Comments/Current

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Services Requested

CAR level of care

____1	____2	____3	____4
____0-36mo		____RBMS	____ICF-MR

Service	Provider ID	Start Date	End date	Units	RVUs
H0032TF				1	0
T1007TFHF				1	0
	SEE ATTACHED RVU PAGE				
				Total RVU	

Client Assessment Record

DOMAIN		CURRENT	PAST
1. FEELING/MOOD/AFFECT	SCORE		
2. THINKING/MENTAL PROCESS IQ _____ MSE_____	SCORE		
3. SUBSTANCE ABUSE	SCORE		
4. MEDICAL/PHYSICAL	SCORE		
5. FAMILY	SCORE		
6. INTERPERSONAL	SCORE		
7. ROLE PERFORMANCE	SCORE		
8. SOCIO-LEGAL	SCORE		
9. SELF-CARE/BASIC NEEDS	SCORE		

COMMUNICATION (required for ICF/MR level of Care)

____ESL	____Hearing Impaired
____Non-Verbal	____Uses Interpreter
____Signs	____Uses Mechanical Device
____Fluency	____Speech Impaired

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Substance Abuse/Integrated Requests use the CAR ***OR*** the ASI/T-ASI.

Addiction Severity Index

Problem Area	Score (0-9)
Medical Status	
Employment/Support Status	
Alcohol	
Drugs	
Legal Status	
Family/Social Relationships	
Psychiatric Status	

Teen Addiction Severity Index

Problem Area	Score (0-4)
Chemical (Substance) Use	
School Status	
Employment/Support Status	
Family/Relations	
Peer/Social Relationships	
Legal Status	
Psychiatric Status	

CLINICAL INTERPRETIVE SUMMARY/PROGRESS ON OR BARRIERS TO CURRENT/PREVIOUS GOAL(S) & OBJECTIVES

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Service Plan

Complexity Type	____Low	____Moderate

Needs 1:

Degree of Impairment: _____Mild ____✔____Moderate _____Severe

Goal 1:

Measurable Objectives/Action Steps:	Target Date

Needs 2:

Degree of Impairment: _____Mild _____✔_____Moderate _____Severe

Goal 2:

Measurable Objectives/Action Steps:	Target Date

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Discharge Plan

a. Criteria (member specific behaviors):

b. Estimated Date of Discharge (M/Y) from program and/or agency:

c. Aftercare Plan:

Collaboration with School System (school age children only):

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Addendum

Community Integration

Caregiver Resources (for members under the age of 21):

Member's Strengths/Abilities (in member's own words):

Member's Liabilities/Needs (in member's own words):

Theoretical Approach being utilized with Individual Psychotherapy:

Referrals to other community services:

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Provider Number:

Date Completed:

(R-04-03-09)

Recipient ID #:_____ **Provider #:**_____

Start Date:

SERVICES REQUESTED
(pick only one)

☐ **PG001 – Prevention & Recovery Maintenance**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG002 – Level 1 OP** **____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG003 – Level 2 OP (includes 0-36 mo)**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG004 – Level 3 OP** **____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG008 – Level 4 OP** **____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG015 – Level 4 OP Intensive In home - Child Systems of Care Only**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG019 – ICF/MR** **____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG031 – RBMS** **____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG025 – Exceptional Case – one month only**

SUBMIT THIS FORM ALONG WITH THE
OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION FORM