TEXAS STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES

Clear Form | Print

SECTION I — SUBMISSION

Issuer Name:	Phone:	Fax:	Date:

SECTION II — GENERAL INFORMATION

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

SECTION III — PATIENT INFORMATION

Name:	Phone:	DOB:	☐ Male ☐ Female ☐ Other ☐ 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

☐ Inpatient ☐ Outpatient ☐ Provider Office ☐ Observation ☐ Home ☐ Day Surgery ☐ Other: _____

☐ 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)

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

El Paso First Health Plans-Request for Behavioral Health Services

Page 2 and 3 Not for Use with Mental Health Rehab and Targeted Case Management

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:	

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
Page 2 and 3 Not for Use with Mental Health Rehab and Targeted Case Management

Member 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:	_____