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

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

El Paso First Health Plans-Request for Behavioral Health Services

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

Section XIII.

Anxiety/Phobia

- ☐ Anxiety
- ☐ Panic Attack
- ☐ Phobic Responses
- ☐ Excessive Worry
- ☐ PTSD

Risk Factors

- ☐ Social Isolation
- ☐ Impaired Judgment
- ☐ Aggression
- ☐ Oppositional/Defiant
- ☐ Self injurious

Sleep Patterns

- ☐ Hypersomnia
- ☐ Insomnia
- ☐ Nightmares
- ☐ Traumatic Dreams
- ☐ Hyposomnia

Eating Patterns

- ☐ Increase Appetite
- ☐ Decrease Appetite
- ☐ Bulimia
- ☐ Anorexia

Substance Abuse

- ☐ Alcohol
- ☐ Drugs
- ☐ Active
- ☐ Remission
- ☐ Withdrawal Symptoms

Mood

- ☐ Anger
- ☐ Apathy
- ☐ Blunted/Flat Affect
- ☐ Depressed Mood
- ☐ Elevated/Expansive
- ☐ Grandiosity
- ☐ Hopelessness
- ☐ Irritable
- ☐ Low Self Esteem
- ☐ Tearfulness
- ☐ Mood Swings

Cognition

- ☐ Decrease Concentration
- ☐ Distractibility
- ☐ Impaired Abstract Thinking
- ☐ Memory Impairment
- ☐ Difficulty Making Decisions
- ☐ Hallucinations

Thought Content

- ☐ Flight of Ideas
- ☐ Loose Association
- ☐ Hyper-talkative
- ☐ Pressured Speech
- ☐ Racing Thoughts
- ☐ Delusions
- ☐ Grandiosity
- ☐ Paranoid Ideation

Functionality

- ☐ Obsessions/Compulsions
- ☐ Hypersexual
- ☐ Impaired ability to function at:
  - ☐ Home
  - ☐ School
  - ☐ Work
- ☐ High Risk Behavior
- ☐ Anti-Social Behavior

Activity

- ☐ Decrease in Energy
- ☐ Psychomotor Retardation
- ☐ Restlessness
- ☐ Hyperactivity
- ☐ Impulsiveness

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: _____