Substance Use Disorder Services Prior Authorization Request Form

COMMUNITY HEALTH PLAN of Washington™

APPLE HEALTH (MEDICAID) MEDICARE ADVANTAGE

COMMUNITY HEALTH NETWORK of Washington™

CASCADE SELECT

Fax form to: 206-652-7067
Medicaid 1-800-440-1561
Medicare 1-800-942-0247
CHNW Cascade Select 1-866-907-1906

PLEASE TYPE or WRITE LEGIBLY or request will be returned as unable to process

MEMBER INFORMATION

First Name:	Last Name:	MI:	Date of Birth:
Member ID:	Member Address:	Phone #:	
If retroactively enrolled, provide enrollment date:			

ORDERING PROVIDER INFORMATION

Agency Name:	Contact Person:	Contact Phone Info:	Contact Fax:
Contact Person at this office:	☐ Ordering provider is PCP: PCP's Clinic Name:	☐ Ordering provider is Specialist Speciality:	

PROVIDER INFORMATION

Provider Group/Clinic:	Contact:
Phone:	Fax:
Street Address:	City | State | Zip:
Provider ID/NPI:	
AUTHORIZATION REQUEST START DATE:	
ESTIMATED DURATION OF THIS EPISODE OF CARE:	
Please indicate CLINICAL urgency of request: ☐ Routine ☐ Urgent	

SERVICE PROVIDER INFORMATION

Facility Name:		Facility Address:		
☐ Partcicpating: ☐ Non-Participating	TAX ID: NPI:	Specialty:	Contact Name:	Contact Fax:

DIAGNOSES (Primary and any applicable co occurring diagnoses)
1.
2.
3.
4.

ASAM LEVEL OF CARE REQUESTED					
◯	ASAM Level 2.1 | Intensive Outpatient (IOP)	◯	ASAM Level 2.5 | Partial Hospitalization (PHP)	◯	ASAM Level 3.1 | Clinically Managed Low-Intensity Residential Services
◯	ASAM Level 3.3- 3.5 | Clinically Managed High-Intesnity Residential Services	◯	ASAM Level 3.7 | Medically Monitored Inpatient Services	◯	ASAM Level 4 | Medically Managed Inpatient Services
◯	Other				

REQUESTED CODES (Include Amount and Modifer)							
	Code	Units/ Visits	Modifier		Code	Units/ Visits	Modifier
◯	H0015 Intensive Outpatient			◯	H0011 Inpatient SUD Detox (please write)		
◯	H0018 Short-Term Residential (1-30 days)			◯	Other Code: (please write)		
◯	H0019 Long-Term Residential (31+ days)			◯	Other Code: (please write)		
◯	Inpatient Hospitalization			◯	Other Code: (please write)		

ASSESSMENT AND LEVEL OF CARE
◯ Requested documentation: ASAM Clinical assessment based on level of care requested

Based on the clinical review, please indicate the ASAM recommended level of care:							
◯	Level 2.1	◯	Level 2.1	◯	Level 3.7	◯	Other
◯	Level 2.5	◯	Level 3.3 - 3.5	◯	Level 4		

Is the ASAM recommended level of care different than what is requested?	◯ Yes ◯ No
If yes, please provide the reason for the variance and include supporting clinical documentation:	

SIGNATURE	
Reviewer Name (print):	
Signature/Credential:	Date: