Nevada Medicaid and Nevada Check Up

Behavioral Health Outpatient or Rehabilitative Authorization Request

Upload this request through the Provider Web Portal. Questions? Call: (800) 525-2395

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

REQUEST TYPE: ☐ Initial Prior Authorization ☐ Concurrent Authorization ☐ Unscheduled Revision

☐ Retrospective Authorization – Date of Eligibility Decision:_____

NOTES:

SECTION I. RECIPIENT

Name:	DOB:
Recipient Medicaid ID:	Age:
Specialized Foster Care: ☐ Yes ☐ No	Is the recipient in State/County custody? ☐ Yes ☐ No
State/County Point of Contact:	
Date recipient went into State/County custody:	

SECTION II. ICD-10 DIAGNOSIS

(If using DC:0-3, use the appropriate crosswalk and enter the appropriate ICD-10 diagnosis code and disorder)

Primary Code:	Disorder:
Secondary Code:	Disorder:
Tertiary Code:	Disorder:

SECTION III. ASSESSMENT SCORE

☐ CASII	Score:	Level:	Date:
☐ LOCUS	Score:	Level:	Date:

☐ ECSII or Other Assessment *(specify)*:	Score:	Level:	Date:

SECTION IV. CURRENT MEDICATION(S)

Current Medications (indicate changes since last report)	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

SECTION V. CURRENT SYMPTOMS AND SIGNIFICANT LIFE EVENTS *(List symptoms and/or significant life events that relate to the recipient's Axis I diagnosis and/or that brought the recipient to treatment, e.g., pertinent family information, developmental history, medical issues, sexual history, substance abuse and legal history.)*

SECTION VI. TREATMENT PLAN AND RATIONALE AND PROGRESS SINCE LAST REVIEW *(Identify for each problem/behavior, long and short term goals, strengths, psychosocial supports and progress or regression during the last authorized period.)*

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SECTION VII. PATIENT'S TREATMENT HISTORY, INCLUDING ALL LEVELS OF KNOWN CARE	
Outpatient Therapy	☐ Yes ☐ No Dates:
Outpatient Substance abuse	☐ Yes ☐ No Dates:
Applied Behavior Analysis (ABA)	☐ Yes ☐ No Dates:
Intensive Outpatient Program (IOP)	☐ Yes ☐ No Dates:
Partial Hospitalization Program (PHP)	☐ Yes ☐ No Dates:
Inpatient Psychiatry	☐ Yes ☐ No Dates:
Outpatient Psychiatry/Medication Management	☐ Yes ☐ No Dates:
Psychiatric Residential Treatment Facility	☐ Yes ☐ No Dates:
Previous Rehabilitative Mental Health (RMH) Services (Basic Skills Training, Psychosocial Rehabilitation)	☐ Yes ☐ No Dates**:**
Additional Treatment History *(for QMHP use, if needed)***:**	

SECTION VIII. DISCHARGE PLAN AND ESTIMATED DISCHARGE DATE

SECTION IX. REQUESTED TREATMENT *The requester will be deemed the point of contact for this authorization request and is responsible for dissemination of all information regarding this request*.

"Units per day" multiplied by "Days per Week" multiplied by the total number of weeks in the entire date span equals "Total Units."

	Code	Modifier	Start Date and End Date	Units per Day	Days per Week	Total Units
1						
2						
3						
4						
5						
6						

Coordinating QMHP Attestation

I attest that the above information in this form is accurate.

Coordinating QMHP Signature:_____ Licensed Credential(s):_____

Print Name:_____ Date:_____

Clinical Supervisor Attestation *(The Clinical Supervisor signature is also required if the QMHP is an intern/assistant or acting under the direction of a Clinical Supervisor.)*

I assume professional responsibility for the mental and/or behavioral health services requested per MSM 403.2A.2.

Clinical Supervisor Signature:_____ Licensed Credential(s):_____

Print Name:_____ Date:_____