Mercy Care Substance Use Residential Prior Authorization Request
Fax: **855-825-3165** Phone: **602-263-3000** TTY **711**

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Instructions for Submitting Substance Use Residential Prior Authorization Requests

A determination will be communicated to the requesting provider.

Form Use: Use this form to request prior authorization for Substance Use Residential Treatment for members with a primary substance use diagnosis. This form can be used for members who have co-occurring issues where the substance use disorder is the primary focus of treatment. If member has SMI designation, this application must be submitted by the member's SMI team. To ensure timely processing of your request and avoid delays, complete this form in its entirety and submit all clinical documentation as requested.

Please review the plan's website www.MercyCareAZ.org for an electronic version of this form. For complete information related to medical necessity criteria and requirements for this level of care, please refer to AHCCCS Medical Policy Manual Section 320-V

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; 6) request prior authorization of a prescription drug; 7) request a referral to an out of network physician, facility or other health care provider; or 8) request a Single Case Agreement for a non-contracted facility (non-par)

General Form Instructions

- Print with black ink only or type in all capital letters.
- Please place a check mark in the corresponding boxes when appropriate.
- Sections 1 through 6 – Complete these sections in their entirety.
- Section 7 – Please provide required documentation.

DATE OF REQUEST (MMDDYYYY):_____

DATE OF ADMISSION (MMDDYYYY):_____

CURRENT STATUS:

- ☐ ACC Title 19
- ☐ Non Title 19
- ☐ SMI Title 19
- ☐ SMI Non Title 19

SECTION 1 MEMBER INFORMATION

1. FIRST NAME _____
2. LAST NAME _____
3. MI ____
4. MEDICAID ID# _____
5. DATE OF BIRTH (MM/DD/YYY) _____
6. MEMBER PHONE NUMBER (XXX-XXX-XXXX) _____
7. MEMBER PCP's _____
8. PCP PHONE# (XXX-XXX-XXXX) _____
9. SMI CLINIC NAME _____
10. CASE MANAGER NAME/PHONE# _____
11. DOES THE MEMBER HAVE OTHER INSURANCE ☐ YES ☐ NO
12. OTHER INSURANCE NAME: _____

Notes: This form must be completed in its entirety in order to receive a determination. Incomplete forms may lead to delays in processing or lack of authorization. AUTHORIZATION DOES NOT GUARANTEE PAYMENT. ALL AUTHORIZATIONS ARE SUBJECT TO MEMBER ELIGIBILITY ON THE DATE OF SERVICE. TO ENSURE PROPER PAYMENT FOR SERVICES RENDERED, PROVIDER/FACILITY MUST VERIFY ELIGIBILITY ON THE DATE OF SERVICE.

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SECTION 2 – REQUESTING / SERVICES PROVIDER INFORMATION

13. REQUESTING PROVIDER FIRST NAME _____

14. REQUESTING PROVIDER LAST NAME _____

15. CONTACT PERSON (Contact Person for additional questions.) _____

16.SERVICING PROVIDER NAME/FACILITY/AGENCY _____

17. PHONE# (XXX-XXX-XXXX) _____

18. FAX# (XXX-XXX-XXXX) _____

19. TIN _____

20. NPI _____

21. IS THE SERVICING PROVIDER A PAR PROVIDER? ☐ YES ☐ NO

SECTION 3 – DIAGNOSIS CODES AND SERVICE/HCPCS CODES

22. ICD 10/DSM-5CODE(s)	23. CODE DESCRIPTION	24. REQUESTED DATE OF SERVICE
		Start Date (MM/DD/YYYY)
		End Date (MM/DD/YYYY)

25. *CPT/HCPS/REV CODE (s)	26. CODE DESCRIPTION	27. # OF UNITS OR VISIT/FREQUENCY

*Note: If you are unsure of the service code(s), include a description of the service in the “Code Description(s)” field.

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SECTION 4 – MEDICAL HISTORY

28. PSYCHIATRIC MEDICATION HISTORY (Attach additional medication history, if needed.)

Medication	Dose Achieved	Duration

29. NON-PSYCHIATRIC MEDICATION HISTORY (Please include MAT medications and attach additional medication history if needed.)

Medication	Dose Achieved	Duration

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SECTION 5 - PHYSICAL HEALTH

30. Known Medical Condition: _____

31. Known Medical Allergies: _____

32. Pregnancy Status: _____

SECTION 6 – CURRENT LEVEL OF FUNCTIONING

33. Is the member able to complete ADLs/ILs independently? ☐ Yes ☐ No

34. Does the member have the ability to self-administer medication? ☐ Yes ☐ No

35. If the member is SMI and not able to complete ADLs or self-administer medication the member may require a higher level of care. Please contact the clinical team to have the SMI CM submit the Prior Authorization Request for Adult Behavioral Health Residential Facility Services (Short Term BHRF – H0018) and Adult Behavioral Health Therapeutic Homes application and follow the BHRF PA process. (Link to BHRF application)

SECTION 7 – REQUIRED DOCUMENTATION

36. Attach the following documents: absence of these documents will delay decision of this request (check each box of documentation provided).

- ☐ Assessment from admitting facility to included substance use history (age of first use, date of last use, amount used) and legal history/DCS
- ☐ ISP/Assessment. For SMI members, include treatment plan from OP team with SUD residential included as a goal
- ☐ ASAM