COLORADO COMMUNITY HEALTH ALLIANCE

Behavioral Health Initial Review Form for Inpatient, PHP and IOP

Providers may submit authorization requests through one of the following three options 24 hours, 7 days a week, including weekends and holidays:

- Electronically using our preferred method via the Interactive Care Reviewer (ICR) tool at **availity.com**
- Fax to **1-844-452-8067**
- Phone at **1-855-627-4685**

Note: This form serves as a general template to help providers when requesting an authorization and is not required. Providers may choose to submit clinical documentation including assessments, treatment plans and progress notes toward goals in lieu of this form. For additional information on medical necessity determinations and standard clinical documentation, see the *Behavioral Health Provider Manual* on **CCHAcares.com/providertools**.

Today's date:	
Contact Information	
Level of care: ☐ Inpatient psychiatric ☐ PHP mental health ☐ IOP mental health	
Member name:	
Member ID or reference #:	Member DOB:
Member address:	
Member phone:	
Primary spoken language:	
Name of utilization review (UR) contact:	
UR contact phone number and/or email address:	UR contact fax number:
Admit date:	
Admitting facility name:	Facility provider # or NPI:
Facility Phone Number:	
Attending physician (first and last name):	Provider # or NPI:

Diagnosis (psychiatric, chemical dependency and medical)

Precipitant to Admission (Be specific. Why is the treatment needed now?)

Risk of Harm to Self

If present, describe:

If prior attempt, date and description:

Risk rating (Select all that apply.):
☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Risk of Harm to Others

If present, describe:

If prior attempt, date and description:

Risk rating (Select all that apply.):
☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Psychosis

Risk rating (0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, N/A = Not assessed):
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

If present, describe:

Symptoms (Select all that apply.):
☐ Auditory/visual hallucinations ☐ Paranoia
☐ Delusions ☐ Command hallucination

Substance Use

Substance (Select all that apply.):
☐ Alcohol ☐ Marijuana ☐ Cocaine
☐ PCP ☐ LSD ☐ Methamphetamines
☐ Opioids ☐ Barbiturates ☐ Benzodiazepines
☐ Other (Describe.):

Urine drug screen: ☐ Yes ☐ No ☐ Unknown

Results (if applicable):
☐ Positive (If selected, list drugs.): ☐ Negative ☐ Pending

BAL: ☐ Yes ☐ No ☐ Unknown

Result (if applicable): ☐ Value: ☐ Pending

Substance use screening (Select if applicable and give score.):

☐ CIWA: ☐ COWS:

Previous Treatment (Include provider name, facility name, medications, specific treatment/levels of care and adherence.)
Current Treatment Plan
Standing medications:
As-needed medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):
Support System (Include coordination activities with case managers, family, community agencies and so on. If case is open with another agency, name the agency, phone number and case number.)

Initial Discharge Plan (List name and number of discharge planner and include whether the member can return to current residence.)
Planned discharge level of care:
Describe any barriers to discharge:
Expected discharge date:
Submitted by:
Phone:

Disclaimer: Authorization indicates that Colorado Community Health Alliance determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.