Nevada Medicaid and Nevada Check Up

Substance Abuse/Behavioral Health Authorization Request

(For provider type 17)

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

Request Date:
REQUEST TYPE: ☐ Initial Prior Authorization – Start date of services:_____ ☐ Concurrent Authorization ☐ Unscheduled Revision (Note that earliest start date may be date of submission of request and end date remains the same as previously authorized services.) ☐ Retrospective Authorization – Date of Eligibility Decision:_____
NOTES:

I. PRESCRIBING PROVIDER *Services must be recommended by a physician or other licensed practitioner of the healing arts.*

Name:	Credentials:
Phone:	Fax:
Address *(City, State, Zip)*:	

II. REQUESTING PROVIDER

Group Name:		
Requesting provider's group NPI:	Phone:	Fax:

III. RECIPIENT

Name:	DOB:
Recipient Medicaid ID:	Age:
Recipient's Living Arrangements (e.g., own home, group home, foster home, parents, relatives):	
Is the recipient in State custody? ☐ Yes ☐ No	Date recipient went into State custody:

IV. RESPONSIBLE PARTY

Organization/Legally Responsible Adult Name:	Phone:
Address *(City, State, Zip)*:	
Relationship to Recipient:	

V. ICD-10 DIAGNOSIS

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

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VI. Substance Use (within the last 90 days) *(List all substances which are the focus of treatment and recovery; specify use as mild, moderate or severe, and provide specific details regarding duration of use, amount, etc.)*

Relevant Laboratory and Toxicology Results (within the last 90 days if available):

Date	Lab Test	Test Results
1.		
2.		
3.		
4.		
5.		

VII. ASAM Level of Care *(Signs, symptoms and level of risk for each dimension for request(s) for initial and continued services)*

Dimension 1: Acute Intoxication:

Dimension 2: Biomedical Conditions and Complications:

Dimension 3: Emotional, Behavioral or Cognitive Conditions and Complications:

Dimension 4: Readiness to Change:
Dimension 5: Relapse, Continued Use or Continued Problem Potential:
Dimension 6: Recovery/Living Environment:
Treatment Service Level:

Clinical Assessor Name and Credentials:	Date:

VIII. COMORBID DISORDERS *(Include psychiatric and physical)*

Quadrant of Care Category I-IV:	Category Definition:
CASII and LOCUS Level:	CASII and LOCUS Score:

IX. CLIENT PROGRESS/REGRESSION SINCE LAST REVIEW *(For initial request please indicate what symptoms or significant life events brought the client to treatment, which may include legal issues. Provide an overview and update this information with each request for review.)*

X. TREATMENT PLAN AND RATIONALE *(Provide an overview of identified problems which are the focus of treatment along with long and short term goals. Include discharge criteria and anticipated date of discharge. Provide a detailed explanation for the intensity of services being requested; list all pertinent groups.)*

XI. CURRENT MEDICATION(S) *(List current medications/dosage. Attach additional sheets if needed to fully document all medications.)*

Medication Name	Dosage/Frequency	Start Date of Medication
1.		
2.		

3.		
4.		

XII. PREVIOUS AND CURRENT TREATMENT *(Describe previous treatment and outcome for addressing substance and any co-occurring disorder(s). This should include services that the client is currently receiving from other providers and could include services to address co-occurring disorders.)*

XIII. 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*.

"Req." is an abbreviation for Requested Service. Enter your requested services on this row. "Units per day" multiplied by "Days per Week" multiplied by the total number of weeks in the entire date span equals "Total Units." Providers please note that provider type 17 may not request codes H2014, H2017, H2012. Please refer to PT 17 code list for covered services for this provider type.

	Code	Modifier	Rendering/Servicing Provider Group Name	Rendering/Servicing Provider Group NPI (provider type 17)		Start Date and End Date *(up to 90 days)*	Units per Day	Days per Week	Total Units
1					Req.				
2					Req.				
3					Req.				
4					Req.				
5					Req.				
6					Req.				

Prescribing Provider/Requester's Name and Credentials: _____

Prescribing Provider/Requester's Signature: _____ **Date:** _____

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 and 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.