Nevada Medicaid and Nevada Check Up

Substance Use/Behavioral Health Authorization Request

(For provider type 17)

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

Please note that form FA-11D requires the signature of the prescribing provider. Requests will be denied if the required signatures are not included.

REQUEST TYPE: ☐ Initial Prior Authorization – Start date of services:_____

☐ Continued 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. REQUESTING PROVIDER

Group Name:	
Group NPI:	Phone:

Group SAPTA Certification Level:

- ☐ Outpatient Behavioral Health Services
- ☐ ASAM Level 1
- ☐ ASAM Level 2.1
- ☐ ASAM Level 2.5
- ☐ ASAM level 3 Residential Services

II. 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:

III. RESPONSIBLE PARTY

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

IV. ICD-10 DIAGNOSIS

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

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V. 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 date of last use, duration of use, amount, frequency, etc.)*

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

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

VI. 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 and Withdrawal Risk:

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:

Clinical Assessor's NPI:	Date:

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

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

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VIII. INITIAL REQUEST *(Please indicate what symptoms or significant life events brought the recipient to treatment, which may include legal issues.)*

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.)*

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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***.**

"Units per day" 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						

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.