KAISER PERMANENTE®

Mental Health Service / Psychiatric Medication Management Reauthorization Request

>> Incomplete forms may delay authorization << **>>One form per patient<<**

Please fax completed form to the Mental Health Access Center (MHAC) fax number listed below. Providers may request an urgent reauthorization by calling first, then faxing the form. **MHAC Fax: 206-630-1683** / Phone: 206-630-1680
Mailed forms are accepted as well: Kaiser Foundation Health Plan of Washington, P.O. Box 9009, Renton WA 98057-9859

Practitioner Name / License: ______________________ **Patient Name:** ______________________

Practitioner NPI: ______________________ **Patient Medical Record Number:** ______________________

Agency/Group: ______________________ **Patient Date of Birth:** ______________________

Site Address*: ______________________ **Authorization Start Date Needed:** ______________________

Mailing Address*: ______________________

Phone Number: ______________________ **Today's Date:** ______________________

FAX Number: ______________________

TID: ______________________

*Unless requested, patient copy of authorization letter will list your address; attach an addendum with a request for removal if needed.

Date Current Episode of Care Began:______________________ Check one: □ Telehealth □ In person

1. Suicidal Homicidal Ideation (SI/HI) / Thoughts of Serious Self Harm:

Current SI	□ Yes □ No	Current Plan	□ Yes □ No	Current Intent	□ Yes □ No	Past Attempts:	□ Yes □ No
Current HI	□ Yes □ No	Current Plan	□ Yes □ No	Current Intent	□ Yes □ No	Past Attempts:	□ Yes □ No

If 'yes' to any Suicidal Homicidal symptoms, please describe safety plan below.

____
____
____

2. Is the patient diagnosed with an alcohol/substance use disorder? □ Yes □ No
   Has the patient been referred for treatment? □ Yes □ No □ Yes but patient declined

3. Current psychotropic medications (include dosage and frequency):

____
____

4. Current Frequency of Visits: Once/Week Twice/Month Once/month Other: ______________
   Planned Frequency of Visits: Once/Week Twice/month Once/month Other: ______________

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5.Treatment Plan

Please Note: In order for KFHPWA to authorize continuing mental health care, treatment needs to be medically necessary, as determined by review of clinical and treatment information provided/available and Medical Necessity Criteria.

Primary Diagnosis: ____ICD 10: Code: __________________

Outline or Describe Associated Symptoms Being Treated : ____

____

Functional Impairment Caused by Symptoms: ____

____

Duration of Symptoms Being Treated: ☐<30 Days ☐1-6 Months ☐7-12 Months ☐>1 Year

Current Symptom Severity: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Goal (Specific and Measurable): ____

____

As Measured by: ____

Score(s) At The Beginning Of Treatment:____________________ Current Score(s):____________________

Treatment Modality: ☐ CBT ☐ DBT ☐ IPT Other ____

Current Treatment Interventions To Meet Goal (Specific, Frequency and Duration) ______________________

____

Outline Progress Towards Goal (including any changes in symptoms and response to treatment as measured by the method outlined above) ____

____

Current Status:

☐ Resolved ☐ Significant Progress ☐ Moderate Progress ☐ Little Progress ☐ No Progress ☐ Declining

If patient is not progressing toward meeting therapeutic goals:

1. Describe reason for lack of progress:____

   ____

2. What changes in treatment (Treatment Modality, Specific, Measurable Goals and Interventions) are being made to help patient progress in treatment?____

   ____

<u>(Optional) applicable needs :</u>

☐ Language needs (please specify): ____

☐ Cultural needs (please specify): ____

☐ Expertise needs (please specify): ____

☐ Modality needs (please specify): ____

☐ Other and additional information: ____

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Secondary Diagnosis**:** ______________________________ICD 10: Code**:** ______________

Outline or Describe Associated Symptoms Being Treated:______________________________

____

Functional Impairment Caused by Symptoms: ______________________________

____

Duration of Symptoms Being Treated: □<30 Days □1-6 Months □7-12 Months □>1 Year

Current Symptom Severity: □ None □ Mild □ Moderate □ Severe

Goal (Specific and Measurable): ______________________________

____

As Measured by: ______________________________

Score At The Beginning Of Treatment:______________ Current Score:______________

Treatment Modality: □ CBT □ DBT □ IPT Other ______________________________

Current Treatment Interventions To Meet Goal (Specific, Frequency and Duration) ______________

____

Outline Progress Towards Goal (including any changes in symptoms and response to treatment as measured by the method outlined above) ______________________________

____

Current Status:

□ Resolved □ Significant Progress □ Moderate Progress □ Little Progress □ No Progress □ Declining

If patient is not progressing toward meeting therapeutic goals:

3. Describe reason for lack of progress:______________________________

____

4. What changes in treatment (Treatment Modality, Specific, Measurable Goals and Interventions) are being made to help patient progress in treatment?______________________________

____

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