KAISER PERMANENTE®

Eating Disorder Authorization / Reauthorization Request

>> Incomplete forms may delay authorization <<

Please fax completed form to the Mental Health Access Center (MHAC) fax number listed below. Providers may request 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: _____

TIN: _____ **Session type - check one**: □ Telehealth □ In person

INSTRUCTIONS: Complete one clinical request form per patient; **all fields must be completed**.
Kaiser Permanente utilizes Level of Care Utilization System (LOCUS) / Child and Adolescent Level of Care Utilization System (CALOCUS) as review guidelines.

1. Date this episode of care began: _____ 2. Number of sessions/days attended to date: _____

3. Current level of care: _____ 4. Planned level of care: _____

Frequency of care:

Individual: _____ time(s)/week _____ h/per session Psychiatry: _____ time(s)/week _____ h/per session

Groups: _____ time(s)/week _____ h/per group Nutrition: _____ time(s)/week _____ h/per session

CURRENT PRESENTATION

5. Current Clinical Presentation (Mental Status Exam, presenting symptoms, changes since last review, differences from usual functioning, current impairment, etc.):

Starting BMI:	Current BMI:	Current Weight:	Goal Weight:
Caloric intake goal:	Caloric intake current:	Height:	Weight stable? Y / N

	Current		Last Review	
Binge:	time(s)/day	day(s)/week	time(s)/day	day(s)/week
Purge:	time(s)/day	day(s)/week	time(s)/day	day(s)/week
Exercising:	time(s)/day	day(s)/week	time(s)/day	day(s)/week
Pharmaceutical:	time(s)/day	day(s)/week	time(s)/day	day(s)/week
Restriction	time(s)/day	day(s)/week	time(s)/day	day(s)/week

6.DSM Diagnosis (Dx):

Dx Code:		Description:	
Dx Code:		Description:	
Dx Code:		Description:	

7. Risk of Harm (including Columbia-Suicide Severity Rating Scale score if administered, potential to cause harm to self or others):

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

Columbia Suicide Severity Rating Scale Score: _____

FUNCTIONAL STATUS

8. Functional Status Level (describe ability to care for self with level of Activity of Daily Living, sleeping, eating, social interactions, impairment in fulfilling age-appropriate responsibilities at school, home, work and social situations, etc.):

DEVELOPMENTAL, MEDICAL, ADDICTIVE, & PSYCHIATRIC COMORBIDITY

Please include comorbidities *directly impacting* the presenting problem and level of impact

9. Substance Use (frequency of use, type of substance used, last use):

10. Medical Needs (chronic pain, non-ambulatory, diabetic, etc.):

11. Cognitive Needs (Developmental Disability, Traumatic Brain Injury, Autism Spectrum Disorder, Dementia, etc.):

12. If the member is currently receiving medication management through your program, please list medications, prescriber's name and credentials:

RECOVERY ENVIRONMENT

Living environment, social/familial supports, community engagement

13. Living Arrangement (including any safety concerns):

14. Education/School Plan (Include name of school, grade, IEP/504 info, transition plans, school supports/contacts, if applicable):

15. Social Support Level (level of support at home, school, from community etc., ample, significant, limited, minimal, none):

16. Environmental stressors (recent losses, changes in the family, financial change, work stress, etc.):

RESPONSE TO TREATMENT & ENGAGEMENT

17. Treatment Goals and Progress (patient will be ready for discharge when… and progress made from the intake or last review on goals and how they are measured, including scores of assessments, PHQ9, GAD7, etc):

18. Participation Level & Response to Treatment (Is the member fully engaging and participating? What interventions are working? What interventions are not working, at which stage of change?):

19. FOR MEMBERS <18 YEARS OLD: Parent(s) and Primary Caretaker(s) Engagement (Engaged in treatment? Knowledgeable of pt's condition and needs? Collaborating with clinical and other service providers? Supervising/contributing to the pt's recovery at home?):

20. Barriers to Discharge:

21. Estimated Discharge Date: