KAISER PERMANENTE®

Mental Health Therapy Authorization / 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 KP 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: _____

Email Address: _____

*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. Does the patient have an alcohol/substance use problem? □ Yes □ No
   Has the patient been refereed for treatment? □ Yes □ No □ Yes but patient declined

3. Is patient taking psychotropic medication(s)? □ Yes □ No □ Patient Declined □ No recommended
   If yes,: Prescriber: _____ Medications (name/dosage): _____
   Have you communicated with Patient's Treating Prescriber? □ Yes □ No

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? _____

_____

(Optional) applicable needs :

□ 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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