KAISER PERMANENTE®

Mental Health Therapy Authorization / Reauthorization Request

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

Please fax completed form to the Mental Health Access Center(MHAC) fax number listed below.
MHAC Fax: 206-630-1683 / Phone: 206-630-1680 or toll-free 1-888-287-2680
Mailed forms are accepted as well: Kaiser Permanente MHAC, P.O. Box 34799, Seattle WA 98124-1799

Provider Name: _____ **Today's Date:** _____

Agency: _____ **Patient Name:** _____

Phone Number: _____ **Patient ID Number:** _____

Fax Number: _____ **Date of Birth:** _____

TIN: _____

*** **If you need additional space please attach separate notes to this form. Thank you.** ***

Date Current Episode of Care Began: _____

Primary Diagnosis: _____ **Code:** _____ ☐ DSM ☐ ICD-10

Secondary Diagnosis: _____ **Code:** _____ ☐ DSM ☐ ICD-10

1. **Suicidal/ Homicidal Ideation/ Thoughts of Serious Self Harm**: Current: ☐ Yes ☐ No Past: ☐ Yes ☐ No
   Current Suicide Plan: ☐ Yes ☐ No Current Suicide Intent: ☐ Yes ☐ No Past Attempts: ☐ Yes ☐ No
   Current Homicide Plan: ☐ Yes ☐ No Current Homicide 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 referred for treatment? ☐ Yes ☐ Yes, but patient declined ☐ No

3. **Is patient taking psychotropic medication(s)?** ☐ Yes ☐ No ☐ Not Recommended ☐ Patient Declined
   If yes, please describe: ☐ anti-depressant ☐ mood stabilizer ☐ anti-anxiety ☐ psycho-stimulant
   ☐ anti-psychotic ☐ other ☐ don't know
   If patient is taking medications, who is prescribing them? ☐ Psychiatrist ☐ ARNP ☐ Primary Care Physician
   Other _____ Name of Provider _____
   Have you communicated with: Patient's Treating Prescriber? ☐ Yes ☐ No ☐ N/A

4. **Current Frequency of Visits**: Once/week Twice/month Once/month Other _____
   Planned Frequency of Visits: Once/week Twice/month Once/month Other _____

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

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

Person Completing Form: _____ _____
Name, Title (print) Signature

If additional space is required, please attach an addendum

Please Note: In order for KPWA 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.

CONFIDENTIAL **This information can be disclosed only with written consent of the person to whom it pertains or is otherwise permitted by such regulations (Uniform Health Information Act Title 70.02)**