KAISER PERMANENTE®

Behavioral Health Services
Mental Health Reauthorization Request

****FOR KPMG WELL BEING PROGRAM PLEASE FAX FORM TO 253.383.6200****

>> Incomplete forms may delay reauthorization <<

Please fax completed form to the Behavioral Health Access (BHA) fax number listed below.
BHA Fax: 206-901-6302 / Phone: 206-901-6300 or toll-free 1-888-287-2680

Mailed forms are accepted as well: Kaiser Permanente BHA, P.O. Box 34799, Seattle WA 98124-1799

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

Agency: _____ **Consumer Name:** _____

Phone Number: _____ **Consumer Number:** _____

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

PLEASE SEE *SAMPLE FORM FOR GUIDANCE ON HOW TO COMPLETE THIS FORM. THANK YOU.**

Date Current Episode of Care Began: _____

Behavioral Health Diagnoses Being Treated:

Primary Diagnosis: _____ Code: _____ ☐ DSM 5; ☐ ICD-9

Secondary Diagnosis: _____ Code: _____ ☐ DSM 5; ☐ ICD-9

1. **Suicidal/ Homicidal Ideation/Thoughts of Serious Self Harm**: ☐ Present ☐ Not Present;
   Suicide Plan: ☐ Yes ☐ No Suicide Intent: ☐ Yes ☐ No; Past Attempts: ☐ Yes ☐ No
   Homicide Plan: ☐ Yes ☐ No Homicide Intent: ☐ Yes ☐ No; Past Attempts: ☐ Yes ☐ No

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. **Functional Impairments**: (Current Impact of symptoms on functioning)

	None	Mild	Moderate	Severe	Response to Treatment*	Description
Social	☐	☐	☐	☐	_____	_____
Psychological	☐	☐	☐	☐	_____	_____
Physical Health / Self Care	☐	☐	☐	☐	_____	_____
Work/school	☐	☐	☐	☐	_____	_____

* Response to Treatment: (I) Improving; (NC) No Change; (D) Declining

4. **Is patient taking psychotropic medication(s)?** ☐ Yes ☐ No ☐ Not Recommended ☐ 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 Prescriber: _____

   Have you communicated with the patient's Treating Prescriber? ☐ Yes ☐ No ☐ N/A

   Have you communicated with the patient's Primary Care Physician? ☐ Yes ☐ No

5. **Current Frequency of Visits**: ☐ Once/week; ☐ Twice/month ☐ Once/month ☐ Other: _____
   Planned Frequency of Visits: ☐ Once/week; ☐ Twice/month ☐ Once/month ☐ Other: _____

6. **Number & Type (CPT Codes) of Additional Sessions Requested for the next 12 months**: _____

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Treatment Plan

Please Note: In order for GHC 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 & Associated Symptoms being treated: _____

_____

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

Goal (Specific, Measurable): _____

_____

As Measured by: _____

_____

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

_____

_____

==========

Secondary Diagnosis & Associated Symptoms being treated: _____

_____

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

Goal (Specific, Measurable): _____

_____

As Measured by: _____

_____

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

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_____

_____

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

If additional space is required, please attach an addendum

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