KAISER PERMANENTE®

# Substance Use 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**.

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

3. Current level of care: _____ Level of care requested: _____

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

4. Services requested:

| | | | |
|---|---|---|---|
| Code: | | Number of units: | |
| Code: | | Number of units: | |
| Code: | | Number of units: | |

**CURRENT PRESENTATION**

5. Current Clinical Presentation (Substance(s) used, frequency of use, amount used at a time, last use date, etc):

6.DSM Diagnosis (Dx):

| | | | |
|---|---|---|---|
| Dx Code: | | Description: | |
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**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)**

7. Has patient had previous treatment? □ No □ Yes – when/where? _____

8. Is the treatment court ordered? □ No □ Yes

9. Is the patient taking psychotropic medication (s)? □ No □ Yes
If yes, have you consulted with the treating provider for this condition? □ No □ Yes

10. Collateral services being used now or to be used in the future (check all that apply)

| | Now | Future |
|---|---|---|
| Addiction self-help (AA, Al-Anon, etc) If now, how many per week? _____ | □ | □ |
| Other self help (Parent United, ACOA, Abuse Survivors, AMI, etc) | □ | □ |
| Community Agency (Mental Health, Vocational Rehab, SSA) | □ | □ |
| Other: _____ | □ | □ |

11. Current assessment of patient as per ASAM Dimensions 1-6. Please indicate if the patient has any problems in the six dimensions below. If so, please explain fully.

1. Acute Intoxication and/or withdrawal potential:

2. Biomedical conditions and complications:

3. Emotional, behavioral or cognitive conditions:

4. Readiness for change:

5. Relapse/continued use potential

6. Recovery environment

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12. Treatment plan:

Problem statement: _____

_____

Goals: _____

_____

Interventions: _____

_____

Status: □ Resolved □Significant progress □ Moderate progress □ Little progress □ No progress

Problem statement: _____

_____

Goals: _____

_____

Interventions: _____

_____

Status: □ Resolved □Significant progress □ Moderate progress □ Little progress □ No progress

If you are out of network with Kaiser Permanente – Washington, please submit a copy of your state license for the level of care you are seeking approval for.

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