**THERAPEUTIC BEHAVIORAL SERVICES (TBS)**

**PRIOR AUTHORIZATION REQUEST & REFERRAL FORM**[ ]  Initial Request [ ]  Continuing Request (6 mos.)

 (submitted by SMHP) (Submitted by TBS provider)

\* Indicates a required section for Initial Requests

**Youth Information\*:**

|  |  |  |
| --- | --- | --- |
| \*Name:       | \*DOB:       | \*Medi-Cal or SSN:       |
| \*Current Address:       |
|  School:       |  School District:       |
| \*Parent/Caregiver Name:       | \*Parent/Caregiver Phone:       |

**Referring Party/Therapist Information**\*: ***Please Note: Client must be receiving services from a Specialty Mental Health Provider (SMHP) billing Medi-Cal.***

|  |  |
| --- | --- |
| \*SMHP Name:       |  \*SMHP Credential:       |
| \*SMHP Program Name:       | \*Address:       |
| \*Phone:       | \*Fax:       |

**Additional Referring Party Information:** (*If same as SMHP, please leave blank)*

|  |  |  |
| --- | --- | --- |
| Name:       | Agency:       | Relationship:       |
| Address:       |
| Phone:       | Fax:       | E-Mail:       |

**CWS/Probation Involved:** [ ]  Yes [ ]  No CWS Contact Name:       Probation Contact Name:

|  |  |  |
| --- | --- | --- |
| Phone:       | Fax:       | E-Mail:       |

**Other Party Involvement:**  *(i.e. CASA, Mentor, Attorney, Big Brother/Sister, etc.)*

|  |  |
| --- | --- |
| Name/Relationship:       | Contact Phone:       |
| Name/Relationship:       | Contact Phone:       |

**Specific requests with regard to TBS Coach’s language, culture, gender, etc.:**

**TBS Class Criteria / Eligibility (Completed by SMHP)\*** – *All questions below require completion.*

1. Is Youth a full-scope Medi-Cal beneficiary under age 21? [ ]  **Yes** [ ]  **No** **AND**
2. Is Youth receiving specialty mental health services from a Medi-Cal funded therapist/case manager? [ ]  **Yes** [ ]  **No**
3. Which of the following conditions have been met by the Youth? *(\*Check all that apply, must check a minimum of 1)* [ ] Youth is at risk for emergency psychiatric hospitalization as one possible treatment option, though not necessarily the only treatment option **or** has had at least one emergency psychiatric hospitalization within the past 24 months
 [ ]  Youth is placed in or being considered for placement in a group home facility of RCL 12 or above/STRTP or is in a locked treatment facility for the treatment of mental health needs
 [ ]  Youth may need out of home placement, a higher level of residential or acute care
 [ ]  Youth is transitioning to a lower level of care and needs TBS to support the transition
 [ ]  Youth has previously received TBS while a member of the certified class
 [ ]  Class membership criteria as listed above has not been established but maximum 30 calendar day unplanned contact is requested due to urgent or emergency conditions that jeopardize child/youth current living arrangement

**Medical Necessity Criteria, completed by the SMHP\*:**

1. **\*Diagnosis for focus of TBS**:
2. **\*Client demonstrates impairment as a result of the included diagnosis** (*at least one of the following applies*):
 [ ]  significant impairment in an important area of life functioning
 *e.g., living situation, daily activities, or social support*

**OR**

 [ ]  a reasonable probability of significant deterioration in an important area of life functioning

**OR**

 [ ]  a reasonable probability a person under 21 years of age will not progress developmentally as individually appropriate

1. \***Client meets each of the intervention criteria listed below:**
2. [ ]  The focus of the TBS intervention will address the condition/impairment
3. Expectation that TBS will:

 [ ]  Significantly diminish the impairment **OR**

 [ ]  Prevent significant deterioration in an important area of life functioning **OR**

 [ ]  Allow the child to progress developmentally as individually appropriate

1. [ ]  The condition would not be responsive to physical health care-based treatment
2. **\*Date of most recent Behavioral Health Assessment (BHA), Outpatient Authorization Request (OAR), or**

 **Progress Note that demonstrates the above criteria Click to enter a date.**

1. \*SMHP Clinician is requesting the following TBS services: ***(Must include amount, scope & duration)***

[ ]  Up to 25 hours of TBS Intervention per week - **amount**

[ ]  TBS **scope** inclusive of Assessment (SC48), Plan Development (SC46), Intervention (SC47) and Collateral (SC49)

[ ]  Up to 6 months of TBS Intervention – **duration**

[ ]  Other *(explain any changes to amount, scope or duration being requested. Please note each authorization cycle is 6 months- Re-authorization may be obtained for additional services)*:

**SMHP submitted form to Optum on***:* **Click to enter a date**.

*(Optum shall notify provider of determination within 5 business days of receipt)*

**FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION**

☐ **OPTUM Reviewed BHA, OAR or Progress Note**

☐ **TBS scope, amount and duration authorized as requested: START** **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **END** **DATE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Additional TBS hours authorized per week** (beyond 25 hours per week): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TBS Request is Reduced/Modified as follows:** ☐**scope** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐**amount** \_\_\_\_\_\_\_\_\_\_☐**duration** \_\_\_\_\_\_\_\_\_

**TBS request is** ☐**denied** ☐**modified** ☐**reduced** ☐**terminated or** ☐**suspended**

NOABD was issued to the beneficiary and provider on the following date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Optum unable to confirmSMHP. Authorization is contingent on TBS provider confirming active SMHP claiming Medi-Cal.

**Optum** **Clinician Signature/Date/Licensure**:

***Typically, within two business days of Optum clinician signature, authorization will be forwarded to TBS and referring provider*****^Date pre-authorization received by TBS Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (^*completed by New Alternatives)*