WILLAMETTE VALLEY community health

Authorization Request Form for:
Mental Health or Chemical Dependency Services
Fax Number: 503-581-7422

Provider and Member Information:	
Requester:	Email:
Referred by (if not Requester):	Email:
Agency:	Request Date:
Phone:	Fax:
Member ID:	Member Name: Member Date of Birth:

Authorization Information (OOP Only- indicates authorization is only required for Out of Panel Providers)			
Start Date:		End Date:	
❒	MH Assessment **(OOP Only)**	❒	Detoxification
❒	Medication Management (MH) **(OOP Only)**	❒	Methadone/Suboxone Treatment **(OOP Only)**
❒	Out Patient Therapy (MH) **(OOP Only)**	❒	OPTX-ASAM Level 1 or 2 (circle one) **(OOP Only)**
❒	Residential – ASAM Level 3	❒	ASAM Assessment & UA ONLY **(OOP Only)**
❒	Residential Wait List **^**	❒	Co-Occurring – Select Applicable MH Services
❒	Other –MH or Chem. Dep.	❒	Her Place
❒	Psychological Eval/Testing-See below/back for additional info needed **(OOP Only)** ***For members under 18, guardians should be prepared to participate in testing.*** If member is under 18, guardian information — Is Guardian aware of request*? Yes ☐ No ☐ Name: — Phone:		

^Residential Wait-List-Send the Following Information When a Bed is Available(May be emailed through CIM Ref)	
Residential Provider:	
Date Assess. Faxed to Provider:	Expected Start Date:

NOTES: Additional Documentation Needed with Request

OOP Mental Health Services:
Clinical notes, assessment and/or treatment plan justifying ongoing care.

OOP ASAM Assessment & UA:
Completed ASAM Assessment.

OOP Chemical Dependency Services:
Clinical notes and/or completed ASAM Assessment as appropriate.

For questions on the status of your submitted request, please contact Behavioral Health Coordinators at 503-371-7701 x 329.

Is your office interested in submitting Authorization requests online though the WVCH Secure Provider Portal? Please contact Provider Relations at 503-587-5123 for more information.

Additional information required for Out of Panel Psychological Evaluation/Testing Request ONLY

Please respond to each question to allow for accurate review of the request.
Additional information may be requested if the question for the patient can be addressed with a routine out-patient Mental Health Assessment.

Include Clinical Records: Recent Mental Health Assessment recommending psychological testing including clinical rationale; PCP chart notes indicating medical cause ruled out, if appropriate; Previous psychological evaluation(s), if available.

1. Is the primary or sole purpose of testing to assess a medical condition (e.g., Fetal Alcohol Syndrome, TBI, and Epilepsy)?

Yes	No	

2. What are the specific clinical question(s) testing will answer, and how will testing impact members' treatment plan? Common questions are diagnostic clarification, needing substantiated Autism diagnosis, member not responding to treatment and/or needing treatment recommendations. If asking for diagnostic clarification, please specify which diagnosis (es) you need ruled in/out.

Response:

3. What is (are) member's current mental health diagnosis (es)? Please use ICD-10 codes and descriptions.

ICD 10 codes and descriptions:

4. Has member had previous psychological/neuropsychological testing?

Yes	No	Unknown	

4(a). If yes (above), please request and review records of previous testing prior to submission to determine if referral question is answered by prior testing. If member has had previous testing, please address below why additional testing is needed.

Response (If appropriate):

5. If member is not enrolled in mental health treatment, please provide details as to why the referral question cannot be answered with diagnostic interview, review of records, behavioral observation or collateral information.

Response: