



Prior Authorization for Out-of-Network Mental Health & Substance Use Disorder Services

FYI *Incomplete, illegible or inaccurate forms will be returned to sender.* Please complete the entire form and allow 14 calendar days for decision. **Submission of all relevant clinical information with the request will reduce the number of days for the decision.**



For questions, call Mental Health and Substance Use Disorder Services at: **612-676-6533** or **1-833-276-1185**



To **fax** form and any relevant documentation:

For **initial** admission notifications: **612-884-2033** or **1-855-260-9710**



Submit Request: [UCare's Secure Email Site](#)
Intake: MHSUDservices@ucare.org

MEMBER INFORMATION

UCare ID _____ PMI _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____

ICD-10: _____ Phone _____

SERVICING PRACTITIONER INFORMATION

Practitioner Name _____ NPI Number _____

Facility Name _____ NPI Number _____

Service Location Address _____

City, State, Zip _____

Contact Phone _____ Fax _____

REQUESTER INFORMATION

Request Sent By _____ Email _____

Phone _____ Total Pages Faxed _____

STANDARD REVIEW

Standard review timeframe for an authorization decision is within 14 calendar days or 10 business days from the date the request was received, as expeditiously as the member's health condition requires.

EXPEDITED REQUEST

Only request an urgent/emergent review if waiting the standard review time frame would potentially jeopardize the member's health, life, or ability to regain function. Expedited decision within 72 hours. Billing and retrospective authorizations are not expedited.

Review our provider manual criteria references. Submit documentation to support medical necessity along with this request. Failure to provide required documentation may result in denial of request.

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REASON FOR OUT-OF-NETWORK AUTHORIZATION REQUEST

Referred from another provider

Referring physician name _____

Clinic/Facility _____ Contact Phone Number _____

Access Issues

Member Preference

Network / Benefit Exception

Previous Insurance Approval (*attach previous authorization as necessary*)

SERVICE REQUEST/ DATES/ PROCEDURE CODES/ UNITS

Please list all necessary code(s) and units associated with your visit.

Service Requested: _____

Date of Service _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

PLEASE INDICATE IF THE FOLLOWING DOCUMENTATION IS INCLUDED

Comprehensive Assessment

Individual Treatment Plan (current)

Diagnostic Assessment

Level of Care Assessment (per DHS guidelines)

Discharge Summary

Medication Administration Record

Functional Assessment

Progress Notes (from the past 30 days, if available)

Other documents _____

COMMONLY REQUESTED SERVICES

Confirm service and attach the following documents if applicable:

- Children's Therapeutic Services and Supports (CTSS)**
 - Diagnostic Assessment, Individual Treatment Plan, Progress Notes (from past 60 days) and Discharge Summary
- Day Treatment**
 - Diagnostic Assessment, Functional Assessment, Level of Care Assessment (per DHS guidelines), Individual Treatment Plan, and Progress Notes (from past 60 days) Discharge Summary
- Partial Hospitalization**
 - Intake or Diagnostic Assessment, Functional Assessment, Level of Care Assessment (per DHS guidelines), Individual Treatment Plan, and Progress Notes (from past 60 days) and Discharge Summary
- Psychological & Neuropsychological Testing**
 - Diagnostic Assessment (within 180 days), Level of Care Assessment, Specific Tests to be Administered, Individual Treatment Plan, and Progress Notes (from past 60 days)
- Psychotherapy (Individual, Group or Family)**
 - Intake or Diagnostic Assessment
- Outpatient Substance Use Disorder Treatment**
 - Comprehensive Assessment, Treatment Plan, Recent Treatment Plan Review, Progress Notes, and Discharge Summary (if applicable)

Additional Information that may support medical necessity: