# Magellan Behavioral Health of Pennsylvania, Inc.
# Treatment Authorization Request
## 90837 for Mental Health and Substance Use Disorder Treatment

Please note the current authorization guidelines are as follows:

- **Drug and Alcohol Providers who are licensed as a Narcotic Treatment Center** – may be authorized up to 12 sessions for one calendar year
- **Mental Health Outpatient MH providers and Drug and Alcohol Providers who are not licensed as a Narcotic Treatment Center** – may be authorized up to four sessions for a three-month time frame (1 unit = 1 session)

☐ Bucks County ☐ Cambria County ☐ Lehigh County ☐ Montgomery County ☐ Northampton County

Select the appropriate level of care/documentation:

☐ Mental Health (Outcome Code: 500/CPT: 90837/Prob Type: 001/Mod1: U4)

☐ Substance Use Disorder (Outcome Code: 500/CPT: 90837/Prob Type: 002/Mod1: U4)

Type of Request: ☐ Initial Request ☐ Concurrent Request

Member Name: _____ Date of Birth: _____

MA ID Number: _____ Date of Request: _____

Provider Name: _____

Provider MIS #: _____

Provider Contact: _____

Provider Email: _____

Provider Phone #: _____

Provider Fax #: _____

I. What is the need for the extended sessions?

_____

_____

_____

_____

II. Date Range of Services Requested*: _____ Sessions: _____

*Services may only be requested 48 hours prior to the date of this request. If outside of that timeframe, a retrospective request must be submitted.

III. Current Diagnosis with Codes (DSM 5)

Dx 1: _____ Code: _____

Dx 2: _____ Code: _____

Dx 3: _____ Code: _____

Dx 3: _____ Code: _____

Member Name: _____ Date: _____

IV. Current Medications:

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

Medication: _____ Dosage: _____ Frequency: _____

V. Other current supports and services involved with member (family, community, support groups, and other mental health/substance abuse services).

_____

_____

_____

_____

*I verify that the information provided in this report is an accurate representation of member's status. I verify that I am following the current authorization guidelines as noted throughout this form.*

*By checking the box below and printing my name, I attest that all of the information provided is accurate and complete.*

☐ _____ _____

Printed Name of Requestor Date