Utilization Management Behavioral Health Request for Authorization Form

CareFirst
Family of health care plans

INSTRUCTIONS

For all Mental Health (MH) and Substance Use Disorder (SUD) service requests, please complete all fields and attach clinical documentation to support the medical necessity of the service(s) requested. Incomplete information may delay processing of your request. Request review timelines vary and some may take up to 15 days. Review timelines are based on applicable NCQA, state and federal requirements.

For services that do not require prior clinical review, please use this form and send to the appropriate fax number listed, or call Precertification at **1-866-PRE-AUTH (773-2884)**, option 1.

Participating Providers: To check the status of the authorization, visit CareFirst Direct at **carefirst.com**.

For assistance on which services require prior authorization, call 1-866-PRE-AUTH (773-2884) or navigate to the **in-network** or **out-of-network** webpages.

FOR SERVICES THAT REQUIRE CLINICAL REVIEW FAX TO THE NUMBERS LISTED

For Inpatient & Residential (MH & SUD) **admissions**—*fax completed form with admission clinical attached.* **Includes step down/level of care change requests (requires updated form and updated clinical notes attached)*	410-505-2433
For Inpatient & Residential (MH & SUD) **concurrent review/discharge**—*form not required, fax updated clinical with; current authorization #, member info, additional days being requested.* ****NOT** for outpatient services or step down/level of care change requests.*	410-505-2789
Outpatient Behavioral Health (for MH & SUD services requiring prior authorization)	443-753-2333
Applied Behavior Analysis; please use UM ABA request form	

MEMBER INFORMATION

Member Name	Member ID	Date of Birth

REQUESTOR DETAILS

Office Contact (or Referring Provider, if required)	Date	Phone Number
Email		Fax Number

If requesting Out-of-Network services for a BlueChoice member, please submit a letter of medical necessity explaining why services cannot be provided In-Network.

FOR MENTAL HEALTH (MH) SERVICE REQUESTS

◯ Acute Inpatient ◯ Crisis Bed ◯ Residential MH ◯ Partial Hospital (PHP) ◯ Intensive Outpatient (IOP) ◯ Office visit
◯ Other

FOR SUBSTANCE USE DISORDER (SUD) SERVICE REQUESTS

Please select **BOTH** place of service and ASAM level

ASAM Level ◯ 3.7(Detox) ◯ 3.3/3.5 (Residential) ◯ 2.5 (PHP) ◯ 2.1 (IOP) ◯ Other

Place of Service ◯ Office ◯ Outpatient Hospital/Facility ◯ Residential SUD Facility ◯ Inpatient Hospital

SERVICE REQUEST DETAILS	
Admit Date or Date(s) requested	ICD 10 Diagnosis
Procedure Code	# of Units or Days
Procedure Code	# of Units or Days
Procedure Code	# of Units or Days
Procedure Code	# of Units or Days
Procedure Code	# of Units or Days

RENDERING FACILITY OR GROUP (IF APPLICABLE)	
Name	
NPI #	Tax ID #
UR Contact & Phone	
Address	

ATTENDING PHYSICIAN OR RENDERING PROVIDER	
Name	
NPI #	Tax ID #
Phone Number	Fax Number
Address	