BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

PERSON COMPLETING AND SUBMITTING THIS FORM:

Name:	Billing NPI # :	Tax ID #:
Phone:	Fax:	Email:
Facility:	Date Form Submitted:	

MEMBER INFORMATION:

Member Name:	DOB:
State ID #:	Legal Guardian:
Legal Guardian Phone & Email:	

Select the line of business or organization this request is for (*check all that apply*):

- ☐ CHP+ offered by Colorado Access
- ☐ DH MCO
- ☐ Regional Organization (RAE) 3
- ☐ Regional Organization (RAE) 5

Primary diagnosis (ICD10):	Secondary diagnosis (ICD10):

Please make sure to fill out this form in its entirety.

SERVICES:

- ☐ **Inpatient Treatment** - Facility/Provider:
- ☐ **Acute Treatment Unit (ATU)** - Facility/Provider:
- ☐ **Partial Hospitalization** - Facility/Provider:
- ☐ **Day Treatment** - Facility/Provider:
- ☐ **Psychiatric Residential Treatment Facility (PRTF)** - Facility/Provider:
- ☐ **Qualified Residential Treatment Program (QRTP)** - Facility/Provider:
- ☐ **Mental Health Intensive Outpatient Services (IOP)** - Facility/Provider:
- ☐ **Behavioral Health Respite** - Facility/Provider:
- ☐ **Electoconvulsive Therapy (ECT)** - Facility/Provider:
- ☐ **Non-contracted provider requesting routine outpatient services (routine services rendered by our contracted providers do not require prior authorization).** Please specify CPT/HCPC codes and number of services being requested. Please also specify why COA in-network providers cannot be utilized for this member/these services.

Continued on next page

BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST (CONT.)

For psychological testing, please use separate form found here.

For short-term behavioral health services in primary care, please use separate form found here.

SERVICE PRIORITY:

☐ **Prospective** (service has not yet been rendered/member not yet admitted)

☐ **Retrospective** (service already rendered/member admitted without prior authorization). Please explain why prior authorization was not completed:

REMEMBER TO ATTACH CLINICAL NOTES WITH THIS REQUEST TO AVOID PROCESSING DELAYS.

We are not financially responsible for the services that are preauthorized if the patient is not eligible on the date services are provided. This request is not a guarantee of payment. Eligibility must be verified at time service is rendered. For questions regarding eligibility of a member, please call us at the numbers below.

After completing this form, fax it to 720-744-5130 or 877-232-5976 or email to behavioral.health@coaccess.com | 24 hours a day, 7 days a week