BEHAVIORAL HEALTH PRIOR AUTHORIZATION REQUEST

PERSON COMPLETING AND SUBMITTING THIS FORM:

Name:		Facility:
Phone:	Fax:	Date Form Submitted:

MEMBER INFORMATION:

Member Name:	DOB:	
State ID:	SSN:	
Member address:		
City:	State:	Zip:
Member phone:		

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

☐ CHP+ offered by Colorado Access ☐ Regional Organization (RAE) 3

☐ CHP+ State Managed Care Network ☐ Regional Organization (RAE) 5

Primary diagnosis:	Secondary diagnosis:

SERVICES:

☐ **Short-term Behavioral Health Services in Primary Care Setting** - The Department of Health Care Policy and Financing reimburses for 6 visits in a 12-month period in the primary care setting. Any additional visits must be authorized by Colorado Access. With request for authorization, please provide evidence that the first 6 visits were billed to the Department (via fee-for-service), plus evidence of a covered behavioral health diagnosis per the Uniform Service Coding Standards Manual. This applies only to Medicaid members. This is not applicable to CHP+.

- ☐ 90791: # of services being requested ___
- ☐ 90832: # of services being requested ___
- ☐ 90834: # of services being requested ___
- ☐ 90837: # of services being requested ___
- ☐ 90846: # of services being requested ___
- ☐ 90847: # of services being requested ___

☐ **Other Routine Outpatient Treatment** - no authorization required if member is eligible and provider is contracted with Colorado Access *(must offer appointment within seven business days)*

☐ **Inpatient Treatment** - Facility/Provider:

☐ **ATU** - Facility/Provider:

☐ **Day Treatment** - Facility/Provider:

☐ **Short Term Residential** - Facility/Provider:

☐ **Long Term Residential**- Facility/Provider:

☐ **Respite** - Facility/Provider:

☐ **Other** - Facility/Provider:

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.

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After completing this form, fax it to 720-744-5130 or 877-232-5976 | 24 hours a day, 7 days a week

coaccess.com
800-511-5010

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