Reset Form

# Prior Authorization for Out-of-Network Mental Health & Substance Use Disorder Medicare Advantage Plans

**FYI** ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision.

For questions, call Mental Health and Substance Use Disorder Services at: **715-631-7442** or **1-855-931-5264**

**Fax** form and any relevant documents to: 715-787-7314

**Submit Request: :** mhsudservicesMA@aspirushealthplan.com

## MEMBER INFORMATION

Aspirus ID _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____ Phone _____

## ORDERING PRACTITIONER INFORMATION

Practitioner Name _____ NPI Number _____

Address, City, State, Zip _____

Contact Phone _____ Fax _____

## SERVICING CLINIC INFORMATION

Practitioner Name _____ NPI Number _____

Clinic Location Address _____

Facility Phone _____ Fax _____

## REQUESTER INFORMATION

Request Sent By _____ Email _____

Phone _____ Total Pages Faxed _____

| ○ STANDARD REQUEST | ○ EXPEDITED REQUEST |
|---|---|
| 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. | Only request an urgent/ emergent review if waiting the standard review timeframe would potentially jeopardize the member's health, life, or ability to regain function.<br>Medicare decision within 72 hours. Billing and retrospective authorizations are not expedited. |

# Prior Authorization for Out-of-Network MH & SUD Services

## 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: _____

ICD-10: _____ Date of Service _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

Procedure Code _____ Units Requested _____

## DOCUMENTS FOR REVIEW

**Confirm and attach the following documents:**

☐ Comprehensive Assessment

☐ Diagnostic Assessment

☐ Discharge Summary

☐ Functional Assessment

☐ Other documents _____

☐ Individual Treatment Plan (current)

☐ Level of Care Assessment (per DHS guidelines)

☐ Medication Administration Record

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

**Additional Information that may support medical necessity:**