Massachusetts Uniform Prior Authorization Form

For Behavioral Providers

To file electronically, providers in Massachusetts must register for access to the online prior authorization tool:

To file via facsimile send to:
866.217.6837

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

CLEAR FORM

BEHAVIORAL HEALTH — LEVEL OF CARE REQUEST FORM

For Eating Disorders level of care requests, complete the relevant supplemental section on page 2.

MEMBER NAME:	
DOB:	GENDER:
INSURER:	POLICY #:
Requesting Clinician/Facility:	
Phone #:	NPI/TIN #:
Servicing Clinician/Facility:	
Phone #:	NPI/TIN #:
Currently in an ER: ☐ Y / ☐ N	Date and Time of Request:
Service Date for Request:	

LEVEL OF CARE REQUESTED

☐ Inpatient ☐ Partial Hospitalization ☐ Community Stabilization/Treatment (☐ ICBAT ☐ CBAT ☐ CCS/CSU) ☐ Residential
☐ Outpatient Psychotherapy (except 90837/90838) ☐ 90837/90838 (☐ ACT ☐ CBT ☐ Cognitive Processing ☐ DBT ☐ EMDR ☐ Exposure
☐ Functional Family ☐ PCIT ☐ IPT ☐ Other: _____)
☐ Family Stabilization ☐ Other: _____

SERVICE TYPE

☐ Behavioral Health ☐ BH in General Hospital ☐ Dual Diagnosis ☐ Eating Disorder

CHIEF COMPLAINT/REASON FOR REQUEST/DIAGNOSES

Chief Complaint/Reason for Request (Frequency, intensity, duration of symptoms)

☐ mild ☐ moderate ☐ severe ☐ acutely life threatening _____

Are there any functional impairments? ☐ Y / ☐ N

Medications: ☐ none ☐ antidepressant ☐ antianxiety ☐ antipsychotic ☐ mood stabilizer ☐ stimulant ☐ other _____

Primary Psychiatric diagnosis:	ICD/DSM Code:
Secondary Psychiatric diagnosis:	ICD/DSM Code:
Substance Use Disorder diagnosis:	ICD/DSM Code:

Relevant active medical problems ☐ Y / ☐ N Medically cleared ☐ Y / ☐ N Needs further evaluation/intervention ☐ Y / ☐ N

Relevant Active Medical diagnoses:	ICD Code:
Prior Admissions ☐ Y / ☐ N / ☐ Unknown	INPATIENT: # of times _____ most recent _____
SUBSTANCE USE/DETOX: # of times _____ most recent _____	OTHER: (specify) _____ # of times _____ most recent _____

MEDICAL/PSYCHOSOCIAL RISKS AND FUNCTIONAL IMPAIRMENTS *(select all that apply to the current request)*:

1. Suicidal: ☐ Current Ideation ☐ Active Plan ☐ Current Intent ☐ Access to Lethal Means ☐ None ☐ Section 12
☐ Current Suicide Attempt ☐ Prior Suicide Attempt (<1 year) Explain: _____

2. Homicidal/Violent: ☐ Current Ideation ☐ Active Plan ☐ Current Intent ☐ Access to Lethal Means ☐ None
☐ Current Threat to Specific Person ☐ Prior Violent Acts (<1 year) Explain: _____

3. Self-Care/ADLs: ☐ mild ☐ moderate ☐ severe ☐ acutely life-threatening Explain: _____
Highest and Lowest Levels of Functioning (<1 year): _____

4. Self-Injurious Behavior: ☐ mild ☐ moderate ☐ severe ☐ acutely life-threatening Explain: _____
Agitated/Aggressive Behavior: ☐ mild ☐ moderate ☐ severe ☐ acutely life-threatening Explain: _____

5. Medication Adherence: ☐ Y / ☐ N / ☐ Unknown, Other Treatment Adherence ☐ Y / ☐ N Explain: _____

6. Legal Issues, Court/DYS Involvement: ☐ Y / ☐ N Explain: _____

7. Employment Risks: ☐ employed ☐ employment at risk ☐ on/requesting medical leave ☐ disabled ☐ unemployed ☐ Other
Explain: _____

8. Psychosocial/Home environment: ☐ supportive ☐ neutral ☐ directly undermining ☐ home risk/safety concerns ☐ homeless
☐ lives alone ☐ married ☐ single ☐ divorced ☐ separated ☐ dependents ☐ Other
Explain: _____

9. Additional Concerns: ☐ Y / ☐ N Explain: _____

10. Outpatient BH/SUD treatment in place? ☐ Y / ☐ N / ☐ Unknown, Have the outpatient treaters been contacted? ☐ Y / ☐ N

BH Level of Care: Supplemental — for Eating Disorders

Eating Disorders level of care requests ***(complete the following)*****:**

Level of Care:

- ☐ Inpatient Eating Disorders Specialty Unit (medically unstable)
- ☐ Acute Residential Eating Disorders Unit
- ☐ Partial Hospital Eating Disorders Program (seven days per week)
- ☐ Partial Hospital Eating Disorders Program (weekdays, 9–2 or 9–5)
- ☐ Intensive Outpatient Eating Disorders Program (several days per week, a few hours)
- ☐ Outpatient Eating Disorder Program

Height:	Weight:	BMI:	% IBW:
Highest weight:	Lowest weight:	Weight change in one month:	

Orthostatic Vitals: sitting BP _____ / _____ PR ____ standing BP _____ / _____ PR ____

Labs: Potassium _____ Sodium _____ Relevant abnormal labs _____

Abnormal _____

EKG: ☐ Y / ☐ N

Medical Evaluation: ☐ Y / ☐ N If yes, when _____

Recent need for IV hydration: ☐ Y / ☐ N If yes, when _____

Current Symptoms: ☐ dizziness ☐ fainting ☐ palpitations ☐ shortness of breath ☐ amenorrhea ☐ cold intolerance ☐ vomiting blood

Current Behaviors: ☐ binging ☐ purging ☐ restricting ☐ over exercising ☐ None

Current Abuse of: ☐ laxatives ☐ diuretics ☐ diet pills ☐ ipecac ☐ None

Specify other pertinent symptoms, behaviors, or high-risk presentations:

_____

** This form is intended for fully-insured plans only. Not all carriers require prior authorization for the above services; not all levels of care are available in member benefit plans. Providers should consult the health plan's coverage policies and member benefits.*