Humana
Healthy Horizons™ in South Carolina

Healthy Connections

Intensive Outpatient

Please complete form in its entirety and return to:
Email: CorporateMedicaidCIT@humana.com
Fax: **833-441-0950**

Behavioral Health Service Request Form

Choose The Appropriate Request Type

☐ Standard Request	FOR OUT OF NETWORK PROVIDERS ONLY PRIOR AUTHORIZATION IS REQUIRED FOR ALL SERVICES. Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed.
☐ Expedited Request	By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician signature validating expedited request	Date signed

Request Type

☐ Initial ☐ Recertification ☐ Change	Authorization #	Request Date

Member Information

Last name	First name	Date of Birth	
Phone Number	Humana ID#	Gender ☐ Male ☐ Female	
Other Ins. ☐ Yes ☐ No	If yes, please attach a copy of the insurance card or provide the name and contact information of the insurer.	Language Spoken	

Ordering Physician/Practitioner Information

Last Name	First Name		NPI	
Humana ID#	Type	☐ PCP ☐ Specialist	Specialty	
Participating ☐ Yes ☐ No	Phone Number		Fax Number	
Street Address	City, State		Zip	
Name of Requestor	Office Contact (If Different)			

Treating Provider/Practitioner Information

Last Name	First Name	NPI	
Humana ID#	Discipline/Specialty		
Street Address	City, State	Zip	
Phone Number	Fax Number	Office Contact	

Disclaimer: An authorization does not guarantee payment by Humana Inc. Responsibility of payment shall be subject to membership eligibility, benefit limitations, and medical necessity.

SCHL9W4EN0721

Intensive Outpatient Behavioral Health Service Request Form

Treating Provider/Practitioner Information

Last Name	First Name	NPI
Street Address	City, State	Zip
Phone Number	Fax Number	Office Contact

Requested Services

Start Date	End Date	Transition of Care ☐ Yes ☐ No	Continuation of Care ☐ Yes ☐ No
Primary CPT/ICD-10 or HCPS Code(s) and Hours/Units of Each Requested	Description/Condition		

Indicate any change in diagnostic presentation.

Axis I		R/O	
Axis II		R/O	
Axis III			
Axis IV (Psychological Stressors)			
Axis V – Current GAF		Highest GAF in Past Year	

Presenting Problem and Patient Symptomology

Include the date the problem(s) began along with the duration	Psychiatrist involved in care?	☐ Yes ☐ No

Current Symptoms (Check all Apply)

☐ Suicidal/ Homicidal Ideation	☐ Impaired Attention/ Concentration	☐ Hopelessness/ Helplessness	☐ Verbal/Physical/ Sexual Abuse
☐ Substance Abuse/ Dependence	☐ Self-Mutilation	☐ Grandiosity	☐ Cruelty to animals
	☐ Impulsivity	☐ Sleep Disturbance	☐ Motoric Disturbance
☐ Social Isolation	☐ Oppositional	☐ Eating Problems	☐ Memory Impairment
☐ Depressed Mood	☐ Tantrums	☐ Coping with pain	☐ Disorientation
☐ Irritability	☐ Work/School Problems	☐ Rage/Anger	☐ Impaired Judgment
☐ Anhedonia	☐ Hallucinations	☐ Phobia	☐ Lack of Insight
☐ Mood Swings	☐ Delusions	☐ Obsession/Compulsion	☐ Distorted Thinking
☐ Victim	☐ Thought Disturbance	☐ Panic Attacks	☐ Distrustful/Suspicious
☐ Perpetrator	☐ Pressured Speech	☐ Generalized Anxiety	☐ Hyperactivity
☐ Fire setting	☐ Bed wetting		

Rationale

What is the purpose of treatment for this member? Include relevant history.

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Rationale
Identify the treatment goals.
Describe how the treatment plan will affected the treatment outcomes. (Please attach a copy of the current treatment plan)
Are there other reasons treatment is necessary?
Is this treatment court or research related or for admission to a program or school?
Has there been any prior outpatient treatment? ☐ Yes ☐ No If **yes**, please specify the dates.
Treatment failure? ☐ Yes ☐ No If **yes**, please specify the previous treatment.
Current Medications (Please indicate if the member is compliant)

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