FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME

Behavioral Health & Substance Abuse Outpatient Treatment Request Form

When complete, please fax to 1-855-396-5730
Please type or print clearly. Incomplete and illegible forms will delay processing.

Prior authorization is required for the following services: Psychological Testing (separate form: 96101, 96118), ECT (90870), PHP/Day Treatment and Intensive Outpatient Services (on the BH/SA Form).
ECT Services must be prior authorized by telephonic review. Please call 1-888-978-1730

NON PAR Providers: prior authorization and a non-contracted provider form is required for all services.

1. Member Information

Member name _____ Keystone Connect ID# _____ SSN _____ DOB _____

Member address _____ City, State Zip _____ Phone _____

Who referred member for treatment? ☐ Self ☐ PCP ☐ State agency _____ ☐ Other _____

Name of referring agency _____ Phone _____

2. Treating Provider Information

Name (with credentials) _____ ☐ NPI # _____ ☐ PAR ☐ NON PAR ☐ IN CREDENTIALING PROCESS

Phone _____ Address _____ City, State Zip _____ Fax _____

Group name/number _____ Contact name _____ Treating provider signature _____

3. Reason for Services

Primary Reason/Complaint: _____ Start Date Requested: _____

Services requested: Service code(s) _____ Frequency _____

4. DSM Diagnosis

List any and all DSM Diagnoses (BH and Medical):

_____

_____

_____

_____

5. Please answer the following questions

1. **Is the member currently participating in any vocational services?** ☐ Yes ☐ No
2. **Is the member's family or supports involved in treatment?** ☐ Yes ☐ No
3. **Has the member been evaluated by a psychiatrist?** ☐ Yes ☐ No
4. **Is there coordination with other substance abuse providers?** ☐ Yes ☐ No
5. **Is there coordination of care with other behavioral health providers?** ☐ Yes ☐ No
6. **Is there coordination of care with medical providers?** ☐ Yes ☐ No

7. Medications

Is member on prescribed medication(s)? ☐ Yes ☐ No Prescribing physician(s) name(s) _____

Is member compliant with medication(s)? ☐ Yes ☐ No Please list medications and dosages _____

8. Treatment Plan: ***Please attach the current treatment plan.*** Please include documentation related to progress on goals and any changes made as a result.

9. Additional Comments: _____

_____