PerformCARE®

ACT/CTT Prior Authorization Request Form

Member Information

Member Name: _____

DOB: _____ MAID# (10 digits): _____

Member Address: _____ Member Phone: _____

Provider Name: _____ Provider Phone: _____

Person Completing Form: _____

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Release of Information for PerformCare: ☐ Yes ☐ No

Check One: ☐ Initial ☐ Re-Authorization ☐ Additional Units

Requested Start Date: _____

Indicate Service requested: ☐ ACT ☐ CTT

Code	Modifier	Service Description	Units
H0039	HE	ACT/CTT	Max 5000
H0039	HE	ACT/CTT	Indicate Additional Units requested: _____

Include all Current Medications/Dosages (if additional room is needed, please attach full list) :

Admission Guidelines

Member must meet Criteria in A, B, & D and at least (2) criteria under C:

A. ☐ 18 years or older

B. Current SPMI: (Note: Adult Priority Group is not applicable, as Member is not considered to meet ACT Bulletin OMHSAS-08-03 Diagnostic Criteria.)

☐ Schizophrenia ☐ Major Affective Disorder ☐ Psychotic Disorder, NOS

(Please list other Current DSM (Including SUD) AND Physical Health Diagnoses)

_____

C. Must Meet at least (2) of the below:

☐ At least (2) Psychiatric hospitalizations in the past 12 months OR lengths of stay totaling over 30 days in the past 12 months, which includes admissions to psychiatric emergency services. (Specify the dates of admissions, length of stay for each admission, detailed reasons for admission and Providers.)

☐ Intractable (i.e., persistent, or recurrent) severe major symptoms (i.e., affective, psychotic, suicidal, etc. Describe symptoms in their detail)

☐ Co-occurring mental illness and substance abuse disorders with more than (6) months in duration at time of contact. (Specify type of substance, duration, frequency, amount of substance use, and dates including Providers for past SUD treatment).

☐ High risk or recent history of criminal justice involvement, which may include frequent contact with law enforcement personnel, incarcerations, parole, or probation. (Specify dates/location of incarceration and reasons for incarceration or criminal justice involvement).

☐ Homeless, imminent risk of being homeless, or residing in unsafe housing. (Specify dates /reasons).

☐ Residing in an inpatient or supervised residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided OR requiring residential or institutional placement if more intensive services are not available. (Specify)

D. Difficulty effectively utilizing traditional case management or office-based outpatient services OR evidence that the Member requires a more assertive and frequent non-office-based service to meet their clinical needs. (Explain/specify).

Additional Supporting Information: