



Substance Use Disorder Waiver Form
Service Authorization Review
ASAM Levels 3.1/3.5/3.7/3.7 Enhanced

☐ Initial Request

☐ Extension Request

☐ Discharge

NOTE THAT THE MATERIAL CONTAINED IN THE TEXT BOXES AND RATINGS MUST REFLECT THE STATE OF THE MEMBER AT THE TIME OF COMPLETION OF THIS FORM. TEXT MUST REFLECT PROGRESS OR LACK OF PROGRESS SINCE MOST RECENT RATING IF FOR PURPOSES OF CONTINUED STAY. COPY AND PASTED MATERIALS ARE NOT ACCEPTABLE.

Submit Form to Respective Health Plan Using Contact Information Below
PLEASE TYPE INFORMATION IN THIS FORM –

MUST BE COMPLETED BY CREDENTIALLED ADDICTION TREATMENT PROFESSIONAL

This form must be completed, and an updated individualized ASAM assessment must be performed, for a request to be processed. Indicating 'see attached clinical information' will not be accepted as sufficient, and BMS reserves the right to allow health plans to deny a stay if providers do not complete the updated ASAM assessment and/or this form accordingly.

For a request to transition level of care, please treat as Initial Request.

MEMBER INFORMATION		
Today's Date:		Admit Date:
First Name:	Last Name:	
Member ID:		
Address:		
City:	State:	Zip:
Phone:	Date of Birth:	
Parent/Guardian Name:	Phone:	
Does the member have additional health insurance? Yes ☐ No ☐		
Is this admission court ordered? NOTE: if admission is court ordered you must attach/include a copy of the order.		
If yes, please provide additional information:		
PROVIDER INFORMATION		
REFERRING PROVIDER		
Name:	Specialty:	
NPI:	TIN:	
Office Contact Name:		
Phone:	Fax:	
Address:		
City:	State:	Zip:
PROVIDER AGENCY		

Name:		Admitting medical professional:	
NPI:		NPI of admitting medical professional:	
Office Contact Name:			
Phone:		Fax:	
Address:			
City:		State:	Zip:

Discharge Planner Name:			Phone:		
ICD-10 DIAGNOSIS CODE(S) (Enter primary and any applicable co-occurring ICD-10 diagnosis codes)					
1.		3.		5.	
2.		4.		6.	
ASAM LEVELS					
	ASAM LOC	DESCRIPTION	CODE		UNITS/DAYS REQUESTED
☐	3.7	Residential Adult Services ASAM Level 3.7	H2036 1 U7 HF		
☐	3.7	Residential Adult Services ASAM Level 3.7 Enhanced	H2036 1 U7 HF		
☐	3.5	Residential Adult Services ASAM Level 3.5	H2036 1 U5 HF		
☐	3.1	Residential Adult Services ASAM Level 3.1	H2036 1 U1 HF		

SUBSTANCE USE DISORDER TREATMENT HISTORY (initial) (Describe other ASAM Levels of Care utilized in past 12 months or attach clinical note)				
ASAM Level of Care	Name of Provider	Duration	Approximate Dates	Outcome

MEDICATION (Please complete at each submission) Please list medications, start date, dosage, frequency and prescriber below (or attach medication list)				
Name of Medication	Start Date	Dosage	Frequency	Prescriber

KEY TO ASSESSMENT AND SCORING

Please complete ratings section below using ASAM risk rating below for each item:

- 0- **No risk or stable:** Current risk absent. Any acute or chronic problem is mostly stabilized.
- 1- **Mild:** Minimal current difficulty or impairment. Minimal or mild signs and symptoms. Any acute or chronic problems soon able to be stabilized and functioning restored with minimal difficulty.
- 2- **Moderate:** Moderate difficulty or impairment. Moderate signs and symptoms. Some difficult coping or understanding but able to function with clinical and other support services and assistance.
- 3- **Significant:** Serious difficulties or impairment. Substantial difficulty coping or understanding and being able to function even with clinical support. Moderately high intensity of services, skills training or supports needed. **May be in or near imminent danger.**
- 4- **Severe:** Serious, gross or persistent signs and symptoms to tolerate and cope with problems. High intensity of services, skills training or supports needed.

DIMENSION 1 | Acute Intoxication and/or Withdrawal Potential

NOTE: description of relevant considerations and rating must be supported in text box below.

Vital Signs (please include below if requesting level 3.7)
Recent substance use history (include appropriate COWS or CIWA scores below if requesting 3.7)
Current withdrawal symptoms (describe below)
Describe need for medications for OUD or alcohol withdrawal as appropriate
Provide brief summary of the member's needs/strengths and symptoms for Dimension 1
ASAM Level Score in D 1 as defined in key above: (0-4)

DIMENSION 2 | Biomedical Conditions/Complications

NOTE: description of relevant considerations and rating must be supported in text box below.
Ensure that all current medications are included in appropriate boxes above.

Acute physical health concerns (including acute or uncontrolled pain)
Chronic physical concerns
Pregnancy related concerns. Please consider access to reproductive health, need for cervical and breast CA screening, Long acting birth control needs and potential for future pregnancy while the member is in the facility or during DC planning.
History of overdoses with approximate dates/years
Provide brief summary of the member's needs/strengths and symptoms for Dimension 2
ASAM Level Score in D2 as defined above: (0-4)

DIMENSION 3 Emotional/Behavioral/Cognitive Conditions	
NOTE: description of relevant considerations and rating must be supported in text box below.	
	Active psychiatric concerns (complaints by patient must be supported by observation of symptomatology)
	Chronic mental health concerns including history of medication adherence
	Cognitive functioning deficits
	Trauma related needs
	Psychiatric history
Provide brief summary of the member's needs/strengths and symptomatology for Dimension 3	
ASAM LEVEL Score in D 3 as defined above: (0-4)	

DIMENSION 4 Substance use Related risks	
NOTE: description of relevant considerations and rating must be supported in text box below.	
	Likelihood of engagement in risky substance use in current or previous environment
	Likelihood of engaging in other harmful SUD related behaviors in current or previous environment
Provide brief summary of the member's needs/strengths using concrete examples for Dimension 4	
ASAM Level Score in D 4 as defined above: (0-4)	

DIMENSION 5 | Recovery environment
NOTE: description of relevant considerations and rating must be supported in text box below.

	Ability to function effectively in current or previous recovery environment
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	Safety in current or previous recovery environment
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	Support in current or previous recovery environment
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	Cultural perceptions of drug use and addiction
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Provide brief summary of the member's needs/strengths using concrete examples for Dimension 5	

ASAM Level Score in D 5 as defined above: (0-4)
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Provide all supporting clinical documentation to justify your assessment in this dimension and your recommended ASAM Level (via attachments).

**Summary of dimension scores/ratings, utilizing a scale ranging from no risk to severe
Must correspond to ratings above.**

Dimension 1

Dimension 2

Dimension 3

Dimension 4

Dimension 5

Dimension 6 considerations:

1. Identify potential obstacles to care.
2. Does the member have treatment preferences?
3. Is there a need to enhance motivation and how will this be addressed?

Briefly summarize how the member is progressing under the current plan of care

Briefly summarize current barriers to treatment

Discharge planning items: MANDATORY SECTION. MUST BE COMPLETED OR REQUEST WILL NOT BE PROCESSED.

1. Note that all residential treatment programs are required by BMS to complete a standardized Social Determinants of Health (SDOH) tool of your choice in order to assess the member's needs prior to discharge. Below you attest to having completed this tool:
Date of completion: _____ Tool used: _____
Name and credentials of individual completing the tool: _____
PLEASE ensure that the results of the tool are reflected in member's discharge diagnoses as Z codes.
2. Proposed plan for housing:
3. Does the member need identification items (social security card, birth certificate, state issued identification, driver's license), DD214 (certificate of release or discharge from active duty)? Please itemize as applicable.
4. Has the member considered stepping down to a recovery residence? If not, why not? If yes, have applications been submitted and if so, to which facilities?
5. Does the member have primary care or dental issues that need to be addressed during his/her stay? If so, please describe and include plan for addressing: Please include long-acting birth control options for women as desired, STD testing for all, HIV/Hep testing and treatment, flu and covid immunizations as appropriate. Specify.

6. Does the member have SSI/SSDI, veteran's benefits or vocational/educational options post discharge? Specify.
7. What is the projected discharge date?
8. Provide appointments for outpatient SUD/MH and Primary Care/medical/dental post discharge including time/date/provider. Indicating that member "will make appts after discharge" is not acceptable. (This section may be completed just prior to discharge date).

SIGNATURE OF ADDICTION TREATMENT PROFESSIONAL COMPLETING THE FORM	
Name (print):	
Signature/Credential:	Date:



PLEASE SEND FORM TO THE DESIGNATED HEALTHCARE PLAN USING THE CONTACT INFORMATION BELOW FOLLOWING THE TIME FRAME REQUIREMENTS IN THE BMS PROVIDER MANUAL.

CONTACT INFORMATION		
Managed Care Organization	Phone Number	Provider Portal
Aetna Better Health of West Virginia	(888) 348-2922	Provider Secure Web Portal Aetna Medicaid West Virginia
The Health Plan	(800) 624-6961	myplan.healthplan.org
Wellpoint Health Plan of West Virginia	(866) 655-7423	Availity Essentials - Sign In
Highmark	(833) 957-0020	NaviNet Sign In NantHealth