HIGHMARK WHOLECARE

Outpatient Behavioral Health Authorization Request Form

Please Fax Completed Form To: 1-888-245-2027
Behavioral Health Department: 1-800-685-5209

Type of request: □ **Initial** □ **Continued Service/Authorization #_____**

Member Name:	**Member ID Number:**
Member Phone Number:	**Member Date of Birth:**
Facility/Agency:	**Person Completing Form/Phone Number:**
Date of First Service To Be Requested:	**Is Provider Currently In-Network With Gateway?** □ **No** □ **Yes**
Member's Preferred Language:	

Treating Physician's Name:	**Treating Clinician's Name:**
(NPI/Tax ID is necessary only if not in network.)	***(NPI/Tax ID is necessary only if not in network.)***
Address:	**Address:**
Phone Number:	**Phone Number:**
NPI:	**NPI:**
Tax ID:	**Tax ID:**
Medicare/Medicaid ID:	**Medicare/Medicaid ID:**

List All Diagnoses	**Treatment Plan**
(Including Medical Comorbids)	

Member Name:

Current Symptoms: ***(provide clinical rationale for services being requested)***

Partial Hospitalization (PHP) Services	
Number Of Days	**Hours Per Day**

Outpatient ECT/TMS		
CPT Codes & Frequency	**Start Date**	**End Date**
□ **90785:** _____ □ **90867:** _____ □ **90868:** _____ □ **90869:** _____		

Psychological/ Neuropsychological Testing *(check all CPT codes that apply & specify units)*	
CPT Codes & Hours	
□ **96112:** _____	□ **96113:** _____
□ **96116:** _____	□ **96121:** _____
□ **96130:** _____	□ **96131:** _____
□ **96132:** _____	□ **96133:** _____
□ **96136:** _____	□ **96137:** _____
□ **Other:**	

Non-Par Authorization Request *(check all CPT codes that apply & specify frequency)*	
CPT Codes & Frequency	
□ **90785:** _____	□ **90791:** _____
□ **90792:** _____	□ **90832:** _____
□ **99203:** _____	□ **90833:** _____
□ **99204:** _____	□ **90834:** _____
□ **99205:** _____	□ **90836:** _____
□ **99211:** _____	□ **90837:** _____
□ **99212:** _____	□ **90838:** _____
□ **99213:** _____	□ **90847:** _____
□ **99214:** _____	□ **90853:** _____
□ **99215:** _____	
□ **Other:**	
No Authorization required when agency and clinician are in-network	

MEDICATION			
Medication	**Dosage**	**Route**	**Frequency**

Support System

Does Member Have Family/Informal Supports:
□ **No** □ **Yes** ***(Please Specify Below)***

Current living situation:

Substance Abuse Services