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.) **Address:** **Phone Number:** **NPI:** **Tax ID:** **Medicare/Medicaid ID:**	*(NPI/Tax ID is necessary only if not in network.)* **Address:** **Phone Number:** **NPI:** **Tax ID:** **Medicare/Medicaid ID:**

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

REV: 12/2020

Member Name:

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

Partial Hospitalization (PHP) Services		**Outpatient ECT/TMS**		
Number Of Days	**Hours Per Day**	**CPT Codes & Frequency**	**Start Date**	**End Date**
		□ 90785: ___________ □ 90867: ___________ □ 90868: ___________ □ 90869: ___________		

Psychological/ Neuropsychological Testing ***(check all CPT codes that apply & specify units)***	**Non-Par Authorization Request** ***(check all CPT codes that apply & specify frequency)***
CPT Codes & Hours	**CPT Codes & Frequency**
□ 96112: ___________ □ 96113: ___________ □ 96116: ___________ □ 96121: ___________ □ 96130: ___________ □ 96131: ___________ □ 96132: ___________ □ 96133: ___________ □ 96136: ___________ □ 96137: ___________ □ Other:	□ 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