Adult BH HCBS — Prior/Continuing Authorization Request Form

Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), and Child Health Plus (CHPlus) members. Please note, this information is specific to the HARP program only.

☐ **Prior authorization (PA) request (mandatory)**	☐ **Concurrent review authorization request (optional)**

Instructions: The home- and community-based services (HCBS) provider must complete this form for **every** prior authorization (PA) for adult behavioral health (BH) HCBS. When requesting **concurrent authorizations**, the HCBS provider can either complete this form and submit it to the managed care plan for review (which, if requested by the plan, may include a subsequent telephonic review) or request a telephonic review only with the plan to discuss progress made and any modified goals/objectives.

Member information	
Member name:	
Member DOB:	
Member email (optional):	
Member address:	
Plan ID No.:	Member Medicaid ID No.:
Health home:	Health home care manager:

Adult BH HCBS information	
HCBS provider name:	
Provider address:	
Tax ID No.:	Contact person name/title:

Carelon Behavioral Health, Inc. is an independent company providing utilization management services on behalf of the health plan.

providerpublic.mybcbswny.com

NYHM-CD-061784-24 September 2024

Adult BH HCBS information	
Phone No.:	Email address:

Adult BH HCBS requested	
Please select the adult BH HCBS for which authorization is requested (no more than three per request):	
☐ Education support services	☐ Psychosocial rehabilitation (PSR)
☐ Peer supports	☐ Habilitation
☐ Pre-vocational services	☐ Community psychiatric support and treatment (CPST)
☐ Transitional employment	☐ Family support and training (FST)
☐ Ongoing supported employment	☐ Short-term crisis respite (concurrent reviews only)
☐ Intensive supported employment (ISE)	☐ Intensive crisis respite (concurrent reviews only)

Adult BH HCBS No. 1	**Frequency (number of services per week)**	**Intensity (hours per service)**	**Duration (three months)**
List:			
Modality (check all that apply): ☐ Individual ☐ Group ☐ On-site ☐ Off-site			
Adult BH HCBS No. 2	**Frequency (number of services per week)**	**Intensity (hours per service)**	**Duration (three months)**
List:			
Modality (check all that apply): ☐ Individual ☐ Group ☐ On-site ☐ Off-site			
Adult BH HCBS No. 3	**Frequency (number of services per week)**	**Intensity (hours per service)**	**Duration (three months)**
List:			
Modality (check all that apply): ☐ Individual ☐ Group ☐ On-site ☐ Off-site			

Goals and objectives
Clearly state the client's goal(s) and list specific objectives for the period of requested services. Goals must accurately reflect the member's approved adult BH HCBS plan of care. Objectives should be results-oriented, measurable steps toward the overall goal that can be achieved within the requested period of services.
Goal No.1:
Objective 1:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Objective 2:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Objective 3:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Goal No.2:
Objective 1:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Objective 2:
Status: ☐New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)

Goals and objectives
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Objective 3:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Goal No.3:
Objective 1:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Objective 2:
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:
Objective 3
Status: ☐ New ☐ Accomplished ☐ Existing (partially met) ☐ Existing (not met)
Justify continued/modified service for existing (partially met) or existing (not met) objectives:

Describe any other barriers or obstacles to the member's goals/objectives and strategies to address them:
☐ I attest that the member has elected to receive all adult BH HCBS requested above. ☐ I have communicated with the member's health home care manager (not required). ☐ I have communicated with the member's managed care manager (not required.
Provider signature:
Name/title:
Date:

Submission of the authorization form does not preclude telephonic review, which may be required by MCO/behavioral health organizations (BHO). Providers are encouraged to reach out to the MCO/BHO regarding authorization protocol to ensure timely delivery of services for members.

Submission instructions
Please submit this form via email to WNYBehavioralHealthTeam@wellpoint.com.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.