Banner University Health Plans

Provider Training: Updated Out of Home Forms

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Associate Directors, Behavioral Health Department
Banner University Health Plans

Sign in

There is a link in the chat box to sign in. There will be a drawing for a gift card for all who sign in.

Agenda:

1. Out of Home prior authorization forms:
    a. Updates to forms
    b. Examples
    c. SMART Goals

2. Out of Home Concurrent Review Forms and other forms

How do I find the most updated forms?

All of the behavioral health forms are on our website:

https://www.banneruhp.com/materials-and-services/behavioral-health#Behavioral-Health-Materials-and-Forms

This link is on all of Beth’s and Lynda’s email signatures.

What is needed for Behavioral Health OOH Prior Authorization (BHIF, BHRF or TFC/ABHTH)?

1. Behavioral Health Prior Authorization form
2. Out of Home Application
3. Supporting Clinical Documentation including:
   a. Updated Service Plan
   b. Recent Psychiatric eval and/or recent psychiatric progress notes
   c. The most recent assessment, or an assessment updated within the past year.
   d. CFT or ART notes
   e. Any psychological reports or other relevant reports from specialty providers (FBA, etc.)
   f. For Substance abuse treatment—ASAM and/or related clinical documentation.

Banner Health

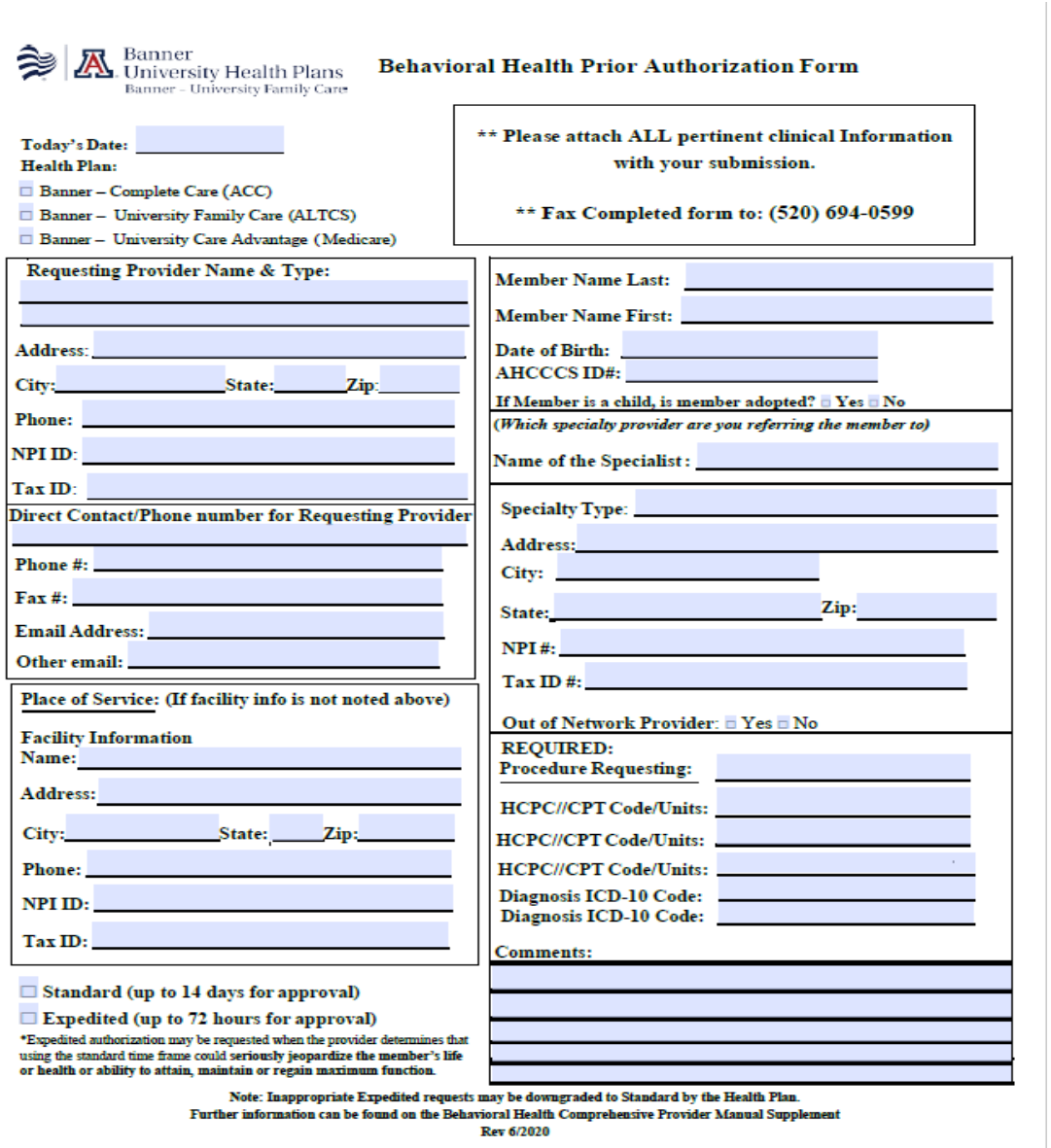
Forms needed for Behavioral Health Out of Home Requests

Behavioral Health Prior Authorization form

1. Obtain from the website
2. TYPE – All areas are fillable and we will not accept hand written forms
3. Save and send with the out of home application and supporting documentation.

Behavioral Health Prior Authorization form

Newest form:



Banner University Health Plans
Banner – University Family Care

Behavioral Health Prior Authorization Form

Today's Date: _____

Health Plan:

- ☐ Banner – Complete Care (ACC)
- ☐ Banner – University Family Care (ALTCS)
- ☐ Banner – University Care Advantage (Medicare)

** Please attach ALL pertinent clinical Information with your submission.

** Fax Completed form to: (520) 694-0599

Requesting Provider Name & Type:

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

NPI ID: _____

Tax ID: _____

Direct Contact/Phone number for Requesting Provider

Phone #: _____

Fax #: _____

Email Address: _____

Other email: _____

Place of Service: (If facility info is not noted above)

Facility Information

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

NPI ID: _____

Tax ID: _____

- ☐ **Standard (up to 14 days for approval)**
- ☐ **Expedited (up to 72 hours for approval)**

*Expedited authorization may be requested when the provider determines that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Member Name Last: _____

Member Name First: _____

Date of Birth: _____

AHCCCS ID#: _____

If Member is a child, is member adopted? ☐ Yes ☐ No

(Which specialty provider are you referring the member to)

Name of the Specialist: _____

Specialty Type: _____

Address: _____

City: _____

State: _____ **Zip:** _____

NPI #: _____

Tax ID #: _____

Out of Network Provider: ☐ Yes ☐ No

REQUIRED:

Procedure Requesting: _____

HCPC//CPT Code/Units: _____

HCPC//CPT Code/Units: _____

HCPC//CPT Code/Units: _____

Diagnosis ICD-10 Code: _____

Diagnosis ICD-10 Code: _____

Comments:

Note: Inappropriate Expedited requests may be downgraded to Standard by the Health Plan.
Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement
Rev 6/2020

Banner University Health Plans

Behavioral Health Prior Authorization form

Part 1

Today's Date: _____

Health Plan:

- [x] Banner – Complete Care (ACC)
- [ ] Banner – University Family Care (ALTCS)
- [ ] Banner – University Care Advantage (Medicare)

Requesting Provider Name & Type:

Name of agency requesting service

Name of individual person filling this out

Address: Address of your agency

City: _____ **State:** _____ **Zip:** _____

Phone: _____

NPI ID: We MUST have one of these NPI or TID

Tax ID: _____

Direct Contact/Phone number for Requesting Provider

Name of person we would contact in the event we have questions

Phone #: _____

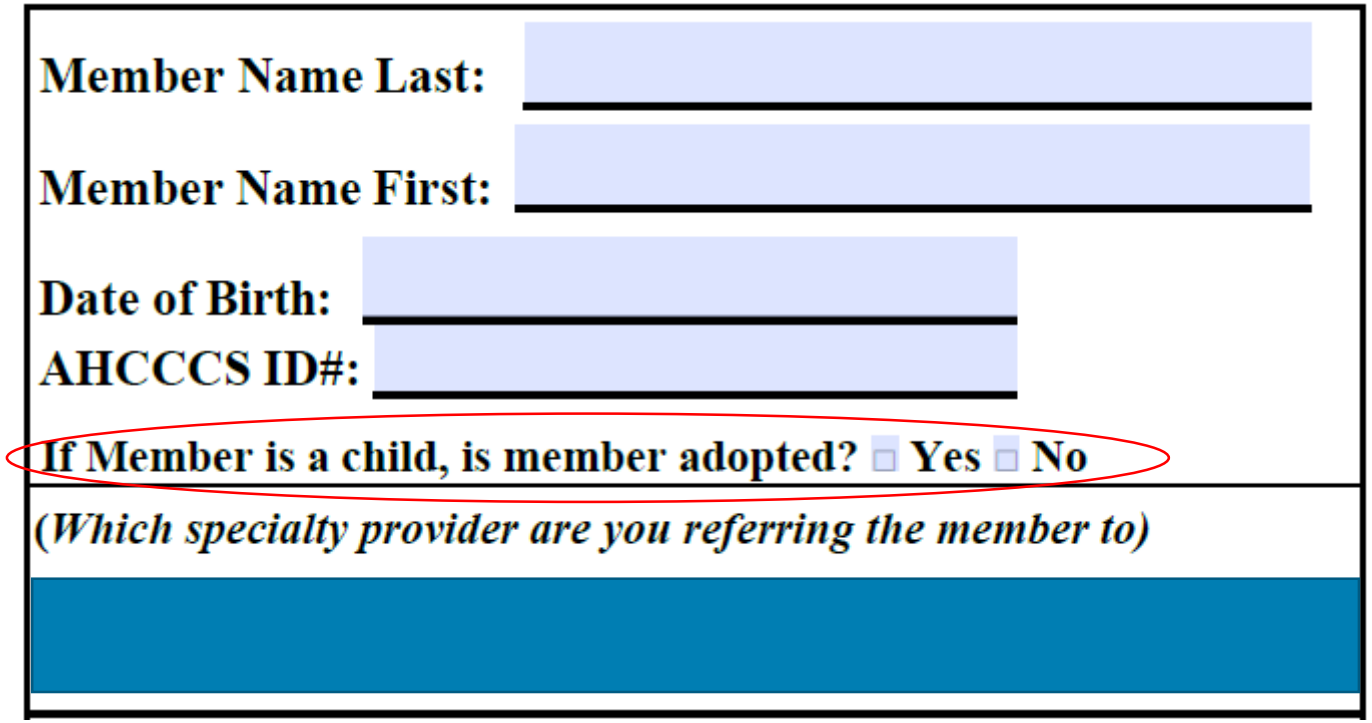
Fax #: _____

Email Address: _____

Other email: Is there another email address?

Behavioral Health Prior Authorization form

Part 2

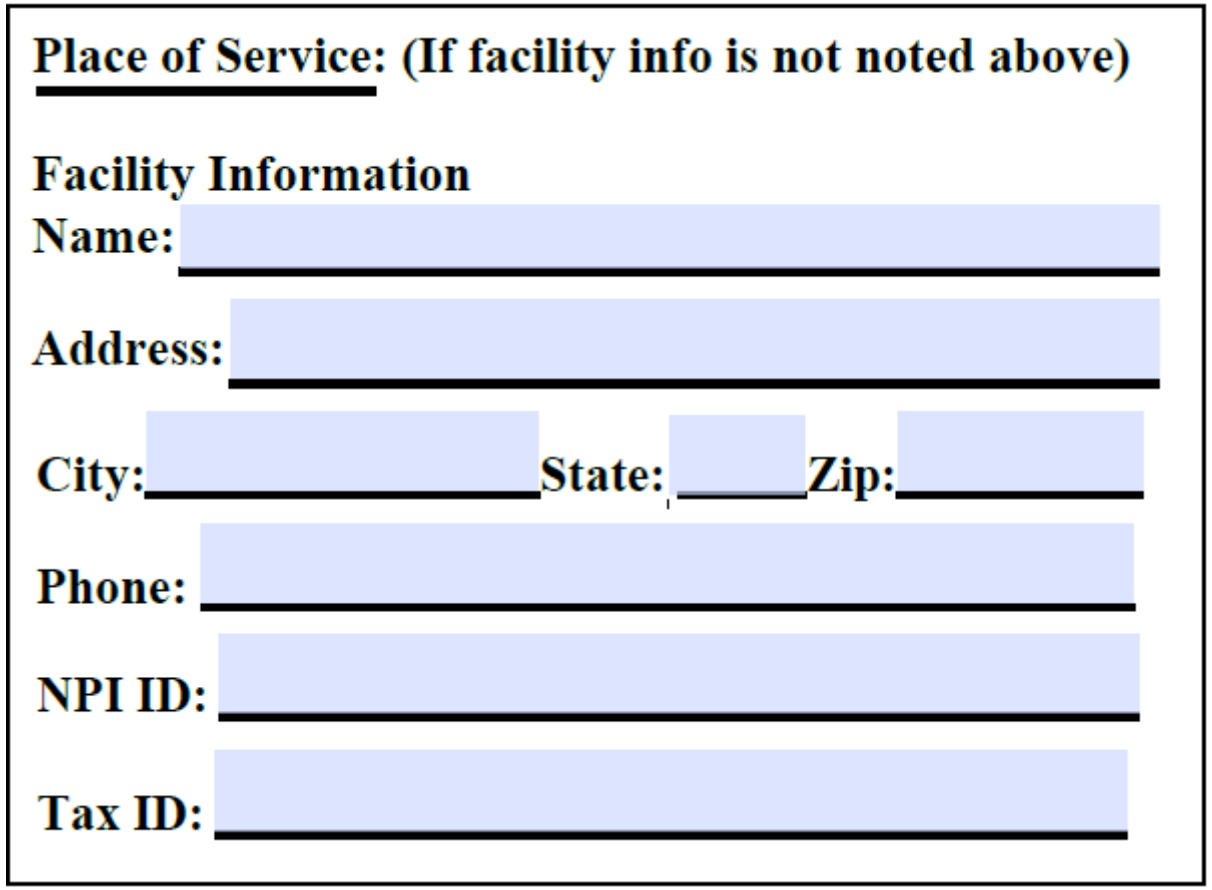


If this is a child, we MUST know whether the member is adopted or not.

Behavioral Health Prior Authorization form

Part 3

If you do not know which facility the member might admit to, you can leave this blank.



Place of Service: (If facility info is not noted above)

Facility Information

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____

NPI ID: _____

Tax ID: _____

Behavioral Health Prior Authorization form

Part 4

For out of home requests, this section can be left blank.
It would be used for other out of network requests

(Which specialty provider are you referring the member to)

Name of the Specialist : _____

Specialty Type: _____

Address: _____

City: _____

State: _____ **Zip:** _____

NPI #: _____

Tax ID #: _____

Out of Network Provider: ☐ Yes ☐ No

Behavioral Health Prior Authorization form

Part 5

Procedure Requesting: BHIF, BHRF or HCTC/TFC/ ABHTH

Codes:

BHIF=0124

BHRF=H0018

HCTC/TFC/ ABHTH=S5109

We MUST have the diagnosis codes.

REQUIRED:

Procedure Requesting:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

Diagnosis ICD-10 Code:

Diagnosis ICD-10 Code:

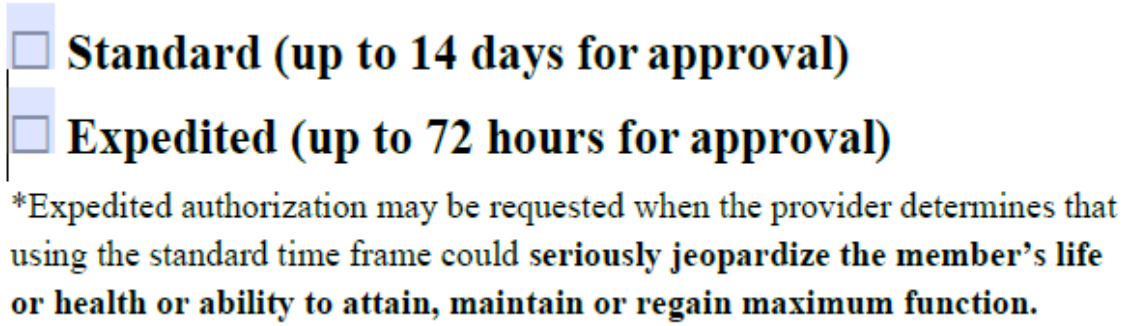
Comments:

Behavioral Health Prior Authorization form

Is it a standard request or an expedited request?

For all BHRF and starting Oct. 1 for TFC for kids, and for BHIF for adopted youth, the request will be treated as an expedited request, per AHCCCS policy.

For BHIF level of care for child members who are NOT adopted, you must keep in mind that an expedited request is only to be used when you have ***determined that using the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.***



☐ **Standard (up to 14 days for approval)**

☐ **Expedited (up to 72 hours for approval)**

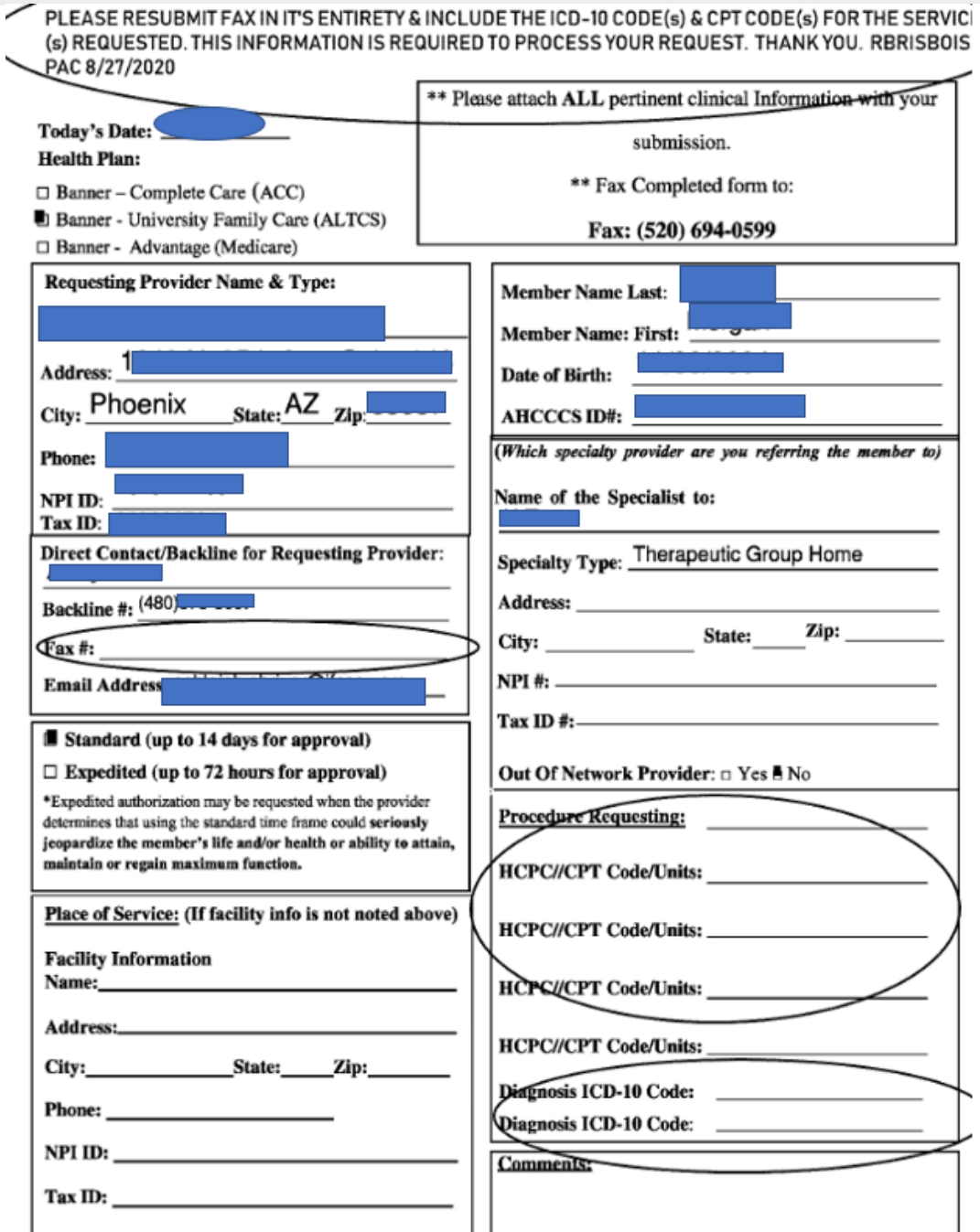
*Expedited authorization may be requested when the provider determines that using the standard time frame could **seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.**

Banner University Health Plans

Behavioral Health Prior Authorization

This is an example of a prior authorization request we have received.

Our coordinator sent this back as there were many areas missing.



PLEASE RESUBMIT FAX IN IT'S ENTIRETY & INCLUDE THE ICD-10 CODE(s) & CPT CODE(s) FOR THE SERVICI
(s) REQUESTED. THIS INFORMATION IS REQUIRED TO PROCESS YOUR REQUEST. THANK YOU. RBRISBOIS
PAC 8/27/2020

** Please attach ALL pertinent clinical Information with your submission.

** Fax Completed form to:

Fax: (520) 694-0599

Today's Date: [redacted]

Health Plan:

☐ Banner – Complete Care (ACC)
■ Banner - University Family Care (ALTCS)
☐ Banner - Advantage (Medicare)

Requesting Provider Name & Type: [redacted]

Address: 1[redacted]

City: Phoenix State: AZ Zip: [redacted]

Phone: [redacted]

NPI ID: [redacted]

Tax ID: [redacted]

Direct Contact/Backline for Requesting Provider: [redacted]

Backline #: (480) [redacted]

Fax #:

Email Address [redacted]

■ Standard (up to 14 days for approval)

☐ Expedited (up to 72 hours for approval)

*Expedited authorization may be requested when the provider determines that using the standard time frame could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function.

Place of Service: (If facility info is not noted above)

Facility Information

Name:

Address:

City: State: Zip:

Phone:

NPI ID:

Tax ID:

Member Name Last: [redacted]

Member Name: First: [redacted]

Date of Birth: [redacted]

AHCCCS ID#: [redacted]

(Which specialty provider are you referring the member to)

Name of the Specialist to: [redacted]

Specialty Type: Therapeutic Group Home

Address:

City: State: Zip:

NPI #:

Tax ID #:

Out Of Network Provider: ☐ Yes ■ No

Procedure Requesting:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

Diagnosis ICD-10 Code:

Diagnosis ICD-10 Code:

Comments:

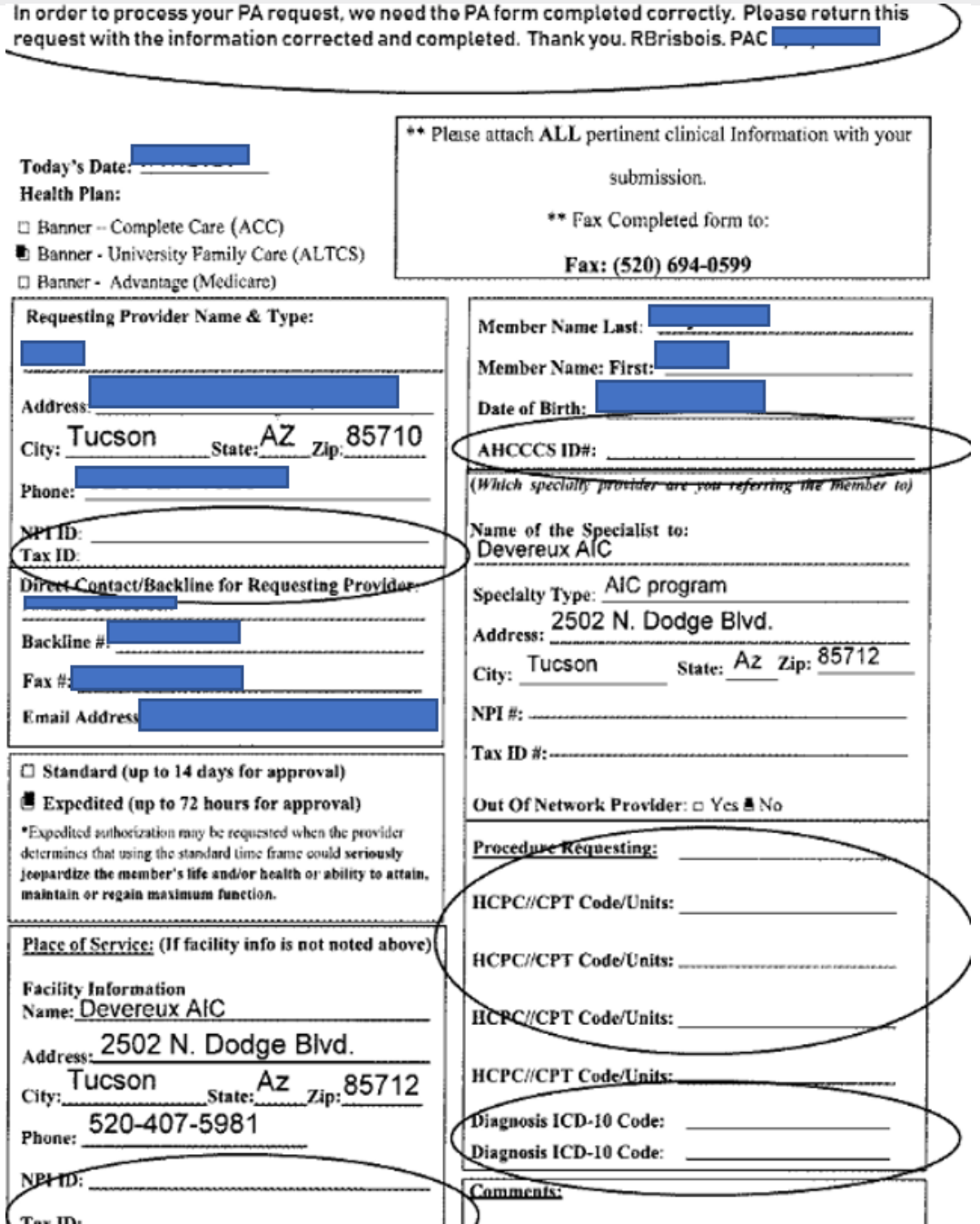
Banner University Health Plans

Behavioral Health Prior Authorization

This is an example of a prior authorization request we have received.

Our coordinator sent this back as there were many areas missing.

When our coordinator has to send any of the forms back, this can potentially delay care the a member.



In order to process your PA request, we need the PA form completed correctly. Please return this request with the information corrected and completed. Thank you. RBrisbois. PAC [redacted]

Today's Date: [redacted]

Health Plan:

☐ Banner – Complete Care (ACC)
■ Banner - University Family Care (ALTCS)
☐ Banner - Advantage (Medicare)

** Please attach ALL pertinent clinical Information with your submission.

** Fax Completed form to:

Fax: (520) 694-0599

Requesting Provider Name & Type: [redacted]

Address: [redacted]

City: Tucson State: AZ Zip: 85710

Phone: [redacted]

NPI ID:

Tax ID:

Direct Contact/Backline for Requesting Provider: [redacted]

Backline #: [redacted]

Fax #: [redacted]

Email Address [redacted]

☐ Standard (up to 14 days for approval)

■ Expedited (up to 72 hours for approval)

*Expedited authorization may be requested when the provider determines that using the standard time frame could seriously jeopardize the member's life and/or health or ability to attain, maintain or regain maximum function.

Place of Service: (If facility info is not noted above)

Facility Information

Name: Devereux AIC

Address: 2502 N. Dodge Blvd.

City: Tucson State: Az Zip: 85712

Phone: 520-407-5981

NPI ID:

Tax ID:

Member Name Last: [redacted]

Member Name: First: [redacted]

Date of Birth: [redacted]

AHCCCS ID#:

(Which specialty provider are you referring the member to)

Name of the Specialist to: Devereux AIC

Specialty Type: AIC program

Address: 2502 N. Dodge Blvd.

City: Tucson State: Az Zip: 85712

NPI #:

Tax ID #:

Out Of Network Provider: ☐ Yes ■ No

Procedure Requesting:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

HCPC//CPT Code/Units:

Diagnosis ICD-10 Code:

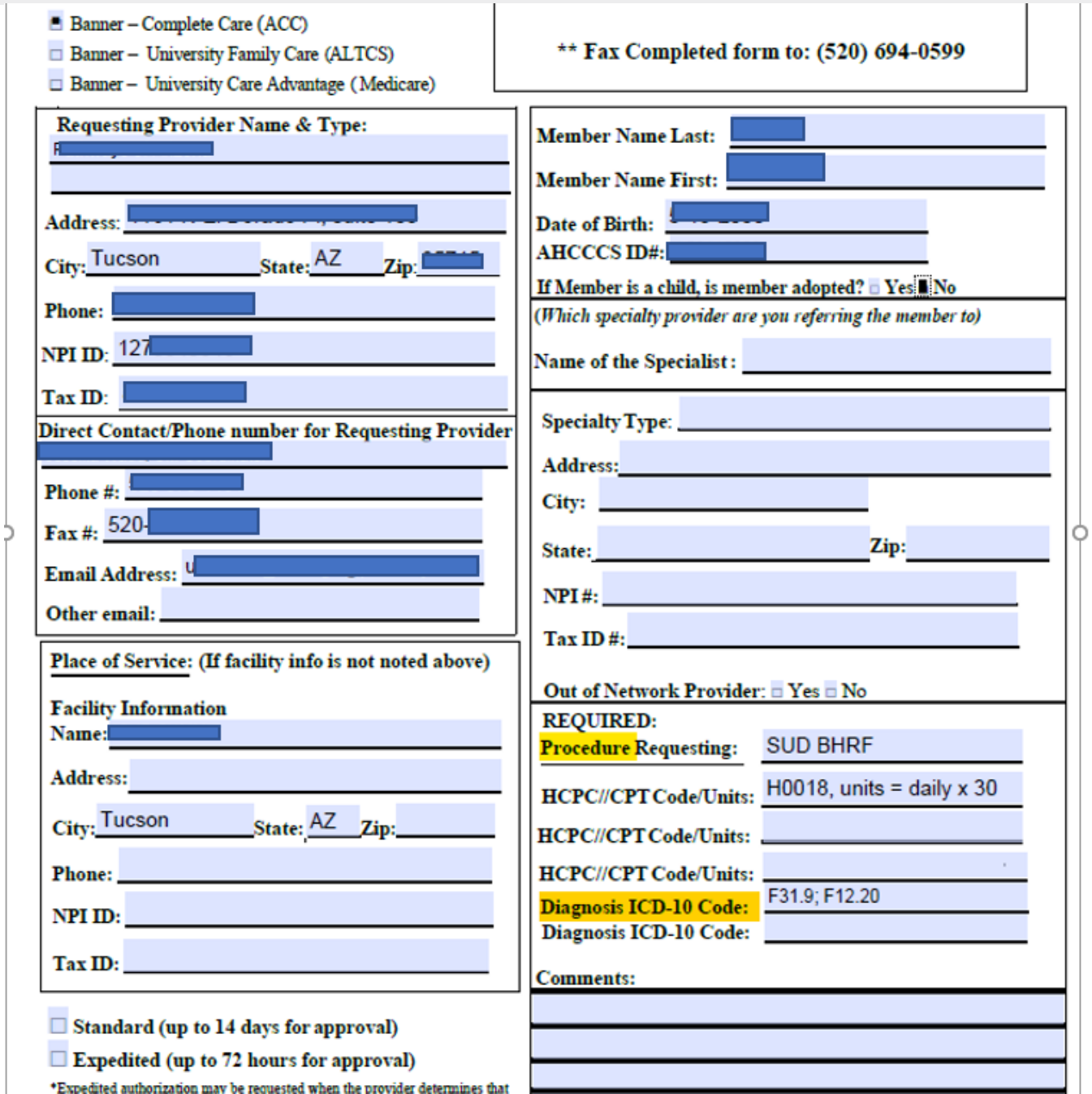
Diagnosis ICD-10 Code:

Comments:

Banner University Health Plans

Behavioral Health Prior Authorization

- This is an example of an excellent prior authorization form we have received.



■ Banner – Complete Care (ACC)
□ Banner – University Family Care (ALTCS)
□ Banner – University Care Advantage (Medicare)

** Fax Completed form to: (520) 694-0599

Requesting Provider Name & Type:
Address:
City: Tucson State: AZ Zip:
Phone:
NPI ID: 127
Tax ID:

Direct Contact/Phone number for Requesting Provider
Phone #:
Fax #: 520-
Email Address:
Other email:

Place of Service: (If facility info is not noted above)
Facility Information
Name:
Address:
City: Tucson State: AZ Zip:
Phone:
NPI ID:
Tax ID:

□ Standard (up to 14 days for approval)
□ Expedited (up to 72 hours for approval)
*Expedited authorization may be requested when the provider determines that

Member Name Last:
Member Name First:
Date of Birth:
AHCCCS ID#:
If Member is a child, is member adopted? □ Yes ■ No

(Which specialty provider are you referring the member to)
Name of the Specialist:

Specialty Type:
Address:
City:
State: Zip:
NPI #:
Tax ID #:
Out of Network Provider: □ Yes □ No

REQUIRED:
Procedure Requesting: SUD BHRF
HCPC//CPT Code/Units: H0018, units = daily x 30
HCPC//CPT Code/Units:
HCPC//CPT Code/Units:
Diagnosis ICD-10 Code: F31.9; F12.20
Diagnosis ICD-10 Code:

Comments:

Banner Health

Forms needed for Behavioral Health Out of Home Requests

Out of Home Application

1. Obtain from the website
2. TYPE – All areas are fillable and we will not accept hand written forms
3. Save and send with the out of home application and supporting documentation.

Behavioral Health Out Of Home Application

Page 1

Banner University Health Plans
Banner – University Family Care

OUT-OF-HOME (OOH) APPLICATION

This request is to be completed (typed) and submitted with the Behavioral Health Prior Authorization.

Send by Fax to:

BUHP Behavioral Health Prior Authorization Department at (520) 694-0599.

This form must be accompanied by the Behavioral Health Prior Authorization Form.

All fields must be filled out. Incomplete or handwritten forms will be returned to sender.

Date of Request:_____ Request for: Adult ☐ Child/Adolescent ☐

Request: ☐ Behavioral Health Residential Facility (BHRF) ☐ Therapeutic Foster Care/Adult BH Therapeutic Home

☐ Behavioral Health Inpatient Facility (BHIF/RTC)

Member's Name:_____ Age:____ DOB:_____

AHCCCS ID:_____ Gender:____

Member's Primary Language: ☐ English ☐ Spanish ☐ Other (specify):_____

Legal Status (Adults only) ☐ COT ☐ Voluntary

Are all ART/CFT members in agreement of this level of care? ☐ Yes ☐ No

Behavioral Health Category: ☐ GMH ☐ SU ☐ Child Funding Source: ☐ T19 ☐ T21

Where is the member currently living? ☐ Home ☐ DOC ☐ House ☐ Jail ☐ Respite ☐ Shelter

☐ Other:_____

If other than home – admission date:_____

Facility:_____

Name of the proposed OOH Facility:_____

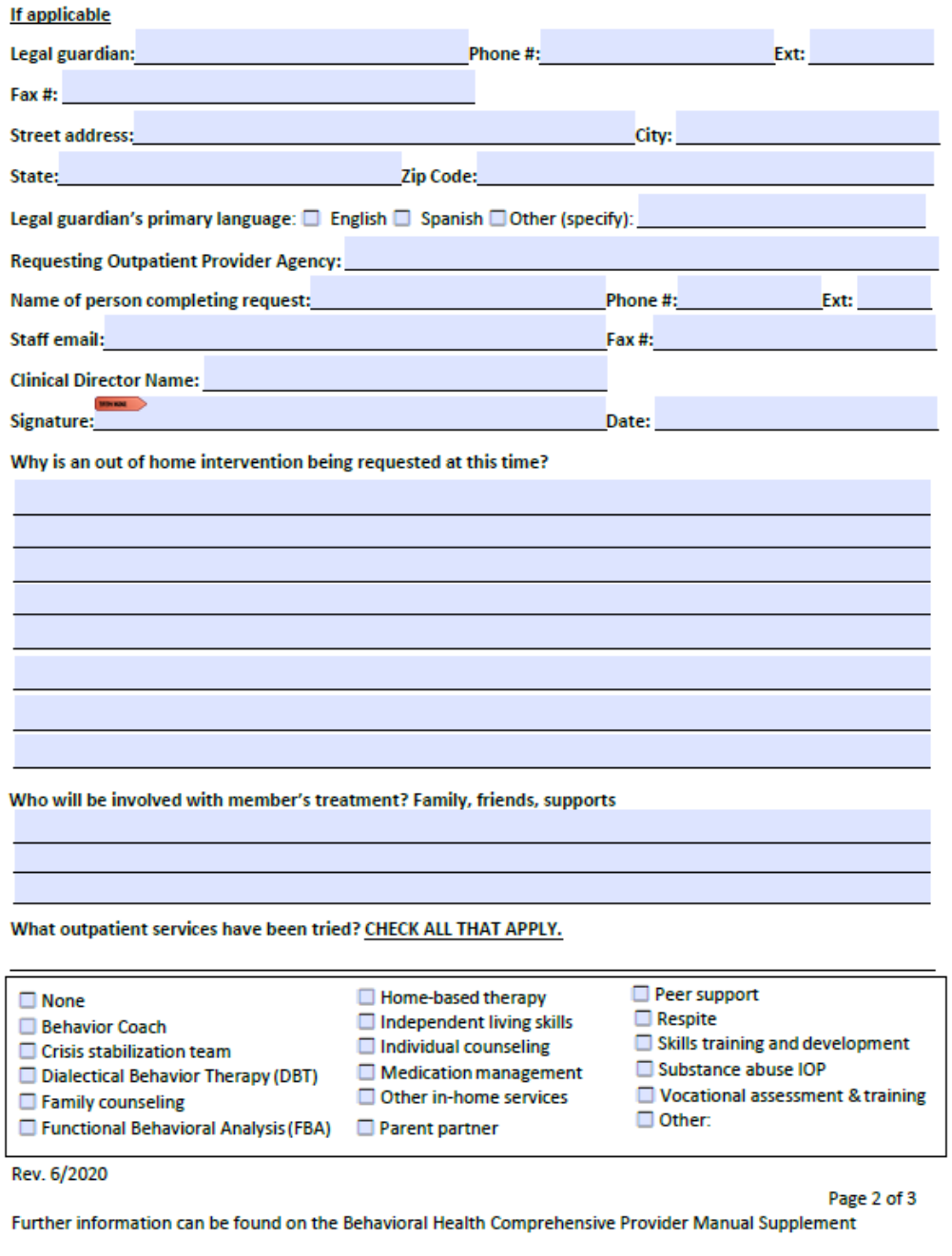
Address:_____

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

Banner University Health Plans

Behavioral Health Out of Home Application

Page 2



If applicable

Legal guardian: _____ Phone #: _____ Ext: _____

Fax #: _____

Street address: _____ City: _____

State: _____ Zip Code: _____

Legal guardian's primary language: ☐ English ☐ Spanish ☐ Other (specify): _____

Requesting Outpatient Provider Agency: _____

Name of person completing request: _____ Phone #: _____ Ext: _____

Staff email: _____ Fax #: _____

Clinical Director Name: _____

Signature: _____ Date: _____

Why is an out of home intervention being requested at this time?

_____

_____

_____

_____

_____

_____

_____

_____

Who will be involved with member's treatment? Family, friends, supports

_____

_____

_____

What outpatient services have been tried? CHECK ALL THAT APPLY.

☐ None	☐ Home-based therapy	☐ Peer support
☐ Behavior Coach	☐ Independent living skills	☐ Respite
☐ Crisis stabilization team	☐ Individual counseling	☐ Skills training and development
☐ Dialectical Behavior Therapy (DBT)	☐ Medication management	☐ Substance abuse IOP
☐ Family counseling	☐ Other in-home services	☐ Vocational assessment & training
☐ Functional Behavioral Analysis (FBA)	☐ Parent partner	☐ Other:

Rev. 6/2020

Page 2 of 3

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

Banner University Health Plans

Behavioral Health Out of Home Application

Page 3

SMART goals here. The goals should be specific, measurable, achievable, relevant AND time based.

Measurable Goals for this Out of Home Admission:

Specify the SMART goals the member will accomplish at the treatment facility. (Specific, Measurable, Achievable, Relevant and Time Based)

Goal:	Objectives:

Required documentation checklist for OOH Admission request: (to be included)

****Please note: OOH request will not be reviewed without the following documentation. ****

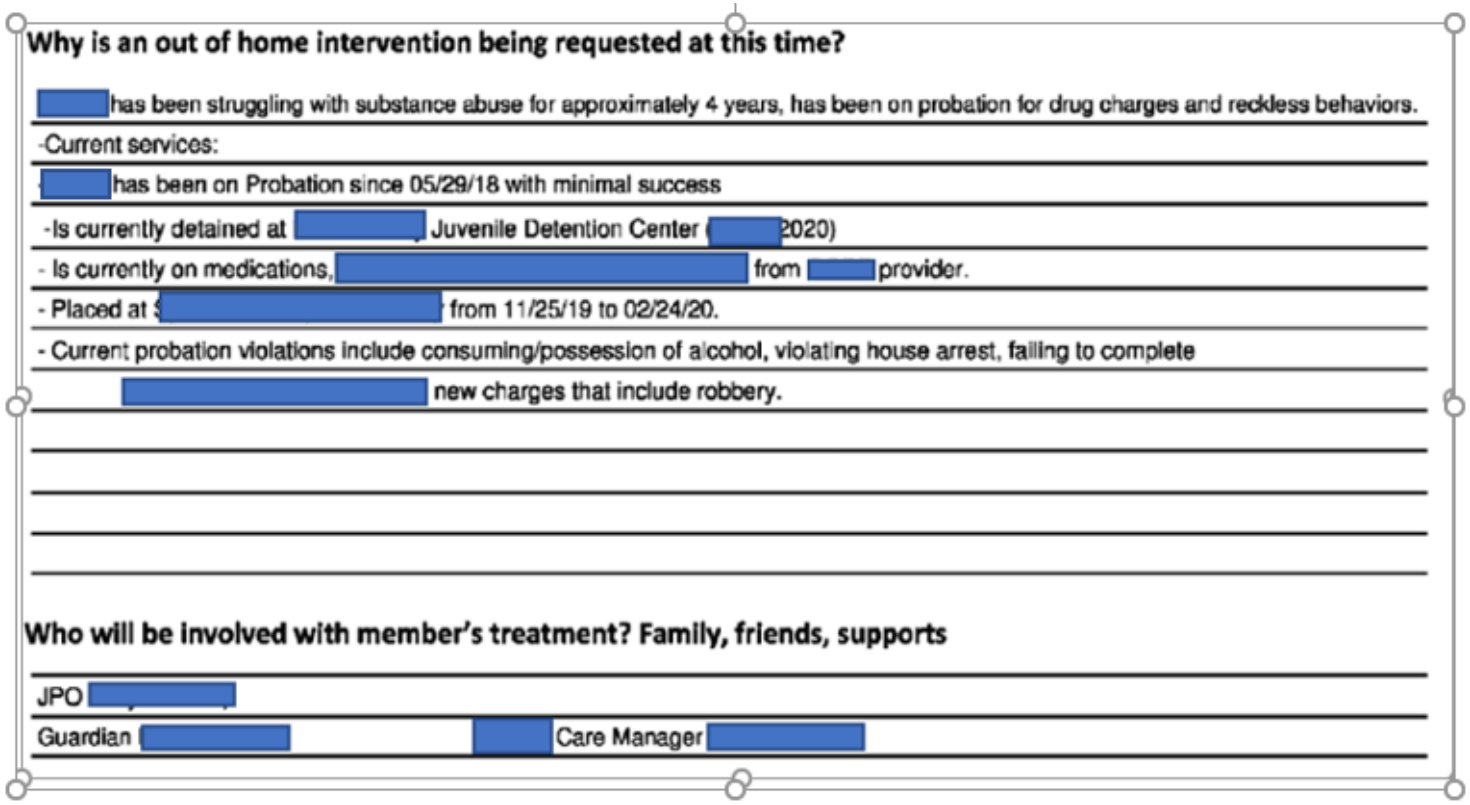
- ☐ ART/CFT notes for the past 30 days
- ☐ ASAM if request is for OOH substance abuse treatment
- ☐ Current Complete Care Plan (must be updated with requested service identified in the plan)
- ☐ Most recent psychiatric evaluation or psychiatric progress note and medication notes
- ☐ Psychiatric progress notes for the last 30 days
- ☐ Medical/physical status/orders/progress notes, (including rationale for personal care services)

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

Out of home application example:

No clinical rationale here.

Using the 12 Principles of Children's Services, there are no other natural supports at all?



Why is an out of home intervention being requested at this time?

[redacted] has been struggling with substance abuse for approximately 4 years, has been on probation for drug charges and reckless behaviors.

-Current services:

[redacted] has been on Probation since 05/29/18 with minimal success

-Is currently detained at [redacted] Juvenile Detention Center ([redacted]2020)

- Is currently on medications, [redacted] from [redacted] provider.

- Placed at [redacted] from 11/25/19 to 02/24/20.

- Current probation violations include consuming/possession of alcohol, violating house arrest, failing to complete [redacted] new charges that include robbery.

Who will be involved with member's treatment? Family, friends, supports

JPO [redacted]

Guardian [redacted] [redacted] Care Manager [redacted]

Out of home application example

No clinical rationale here

The only out patient services that have been tried are Independent Living Skills.

This clearly does not meet medical necessity criteria and was in fact denied.

The goals stated were *"SA TX and services"* and *"Learn coping skills to live a sober life."*

Signature: _____ **Date:** 04/30/2020

Why is an out of home intervention being requested at this time?:

To prevent risk of relapse from alcohol and to provide a safe place to continue Residential services that help the patient with coping skills.

Who will be involved with member's treatment? Family, friends, supports

No one at this time.

What outpatient services have been tried?

☐ None	☐ Home-based therapy	☐ Peer support
☐ Behavior Coach	■ Independent living skills	☐ Respite
☐ Crisis stabilization team	☐ Individual counseling	☐ Skills training and development
☐ Dialectical Behavior Therapy (DBT)	☐ Medication management	☐ Substance abuse IOP
☐ Family counseling	☐ Other in-home services	☐ Vocational assessment & training
☐ Functional Behavioral Analysis (FBA)	☐ Parent partner	☐ Other:

OOH application example:

Excellent example of providing clinical evidence of need for out of home BHRF treatment for substance abuse treatment.

Why is an out of home intervention being requested at this time?

Client's Marijuana, methamphetamine and alcohol use has resulted in serious domestic problems, loss of meaningful relationships, DCS removing her 3 children from her custody in January of 2020, engaging in dangerous sexual behaviors such as not using protection, 2 suicide attempts last year in September, not able to obtain or maintain employment, worsening of psychiatric symptoms such as an increase in her symptoms of anxiety, depression, and PTSD, and impaired social functioning as displayed as poor self-care such as irregular sleeping pattern, not maintaining her nutritional needs and not maintaining her personal hygiene. Client reports she is experiencing symptoms of anxiety 4x daily, symptoms of depression 4x daily, and PTSD symptoms 1-3x daily. Client reports using is the only way she knows how to cope with her daily psychiatric symptoms. Client is at high risk for relapse if not in residential treatment, based on her lack of insight into substance use severity, lack of coping skills such as techniques to reduce and manage her psychiatric symptoms and lack of relapse prevention tools such as techniques to reduce and manage cravings/urges. Client's daily symptoms of anxiety, depression, and PTSD complicate her treatment. See attached.

Who will be involved with member's treatment? Family, friends, supports

Client identifies her niece, daughter, Sponsor and a friend as supports

Out of home application example

This is an excellent example

One of the best examples of a prior authorization request included a list of specific behaviors that the youth was displaying. This is an example of a child who is displaying very concerning sexual behaviors:

- Child was reaching over the seat into his younger brother's space and touching him in his private areas.
- Child assaulted his youngest brother after turning cameras off in the home.
- There were many other very concerning specific behaviors described.
- They also were able to describe all of the services that the family has already tried.

OOH application example:

This is a great description of the member's behaviors and symptoms.

We also see that family members will be involved in this member's treatment.

Why is an out of home intervention being requested at this time?

The client has and is demonstrating maladaptive patterns as they relate to their substance use disorder as evidence by their inability to stop or moderate despite the negative consequences; they use to aviod negative consequences emotions they have and inability to regulate and cope with negative consequences they face as a result of their substance use. Client endorses giving up important social, occupational and recreational activities because of their substance use. Client also reports inability to control the amount they use despite their desire to do so. Client is also endorsing symptoms of Generalized Anxiety Disorder as evidence by excessive anxiety, worry, edginess and restlessness. Client has reported multiple overdoses that required medical attention; with the most recent four months ago. Client lacks the necessary coping skills to process their unresolved grief, physical pain and strained relationships.

Who will be involved with member's treatment? Family, friends, supports

Clients mother and brother.

Out of home application: Goals

Not written as SMART Goals

When goals are not SMART goals, then members are not set up for success.

Measurable Goals for this Out of Home Admission:

Specify the goals the member will accomplish at the treatment facility.

Target Behavior	**Goal**
Example: Decrease craving to low	**A substance free lifestyle**
Learn relapse prevention skills	Remain drug free
Learn positive communication skills	Express when feeling triggered

SMART Goals

- Specific: Does your goal clearly and specifically state what you are trying to achieve? Is it lofty, large and vague?
- Measurable: How will you and the member know if progress is being made on achieving the goals? Can you quantify it or put numbers to outcomes?
- Attainable: Is achieving this goal depending on someone/thing else? Is there anything preventing this goal being accomplished?
- Relevant: Why is the goal important? What values does it reflect? What effect will it have on the member?
- Time bound: When is the member expected to reach the goal? This time frame can change.

SMART Goals

Examples of SMART Goals for Sobriety:

Achieve 60 days of continuous sobriety

- Identify triggers and replacement behaviors within 30 days
- Journal for 15 a minutes a day about pros of sobriety
- Develop a support network of 3 sober friends/peers/ sponsor
- Attend 8 12 Step meetings & decide AA/NA/CA is option for long term sobriety support.

Develop Coping Strategies

- Attend ind/group/family therapy to discuss and own behaviors and impact on others.
- Identify past ineffective coping/choices and develop 5 new behaviors

SMART Goals

Examples of SMART Goals for Mood/Depressive Disorders:

Goal-Member will report an overall improvement in mood in the next 3-6 months, using a rating scale 0-10 (0-low and 10 high)

1)Objective- Member will exercise 2-3 weekly in the next 3-6 weeks

2) Objective-Member will include fruits and vegetables in 3-4 meals weekly

3) Objective- Member will make positive I statements, 1x daily in the next 3-6 weeks

4) Objective- attend all medication appointments and take medication as directed, report all side effects daily

5) Objective- member will attend individual tx to learn about CBT and report on 3 new ways to think about situations to reduce symptoms

Banner Health

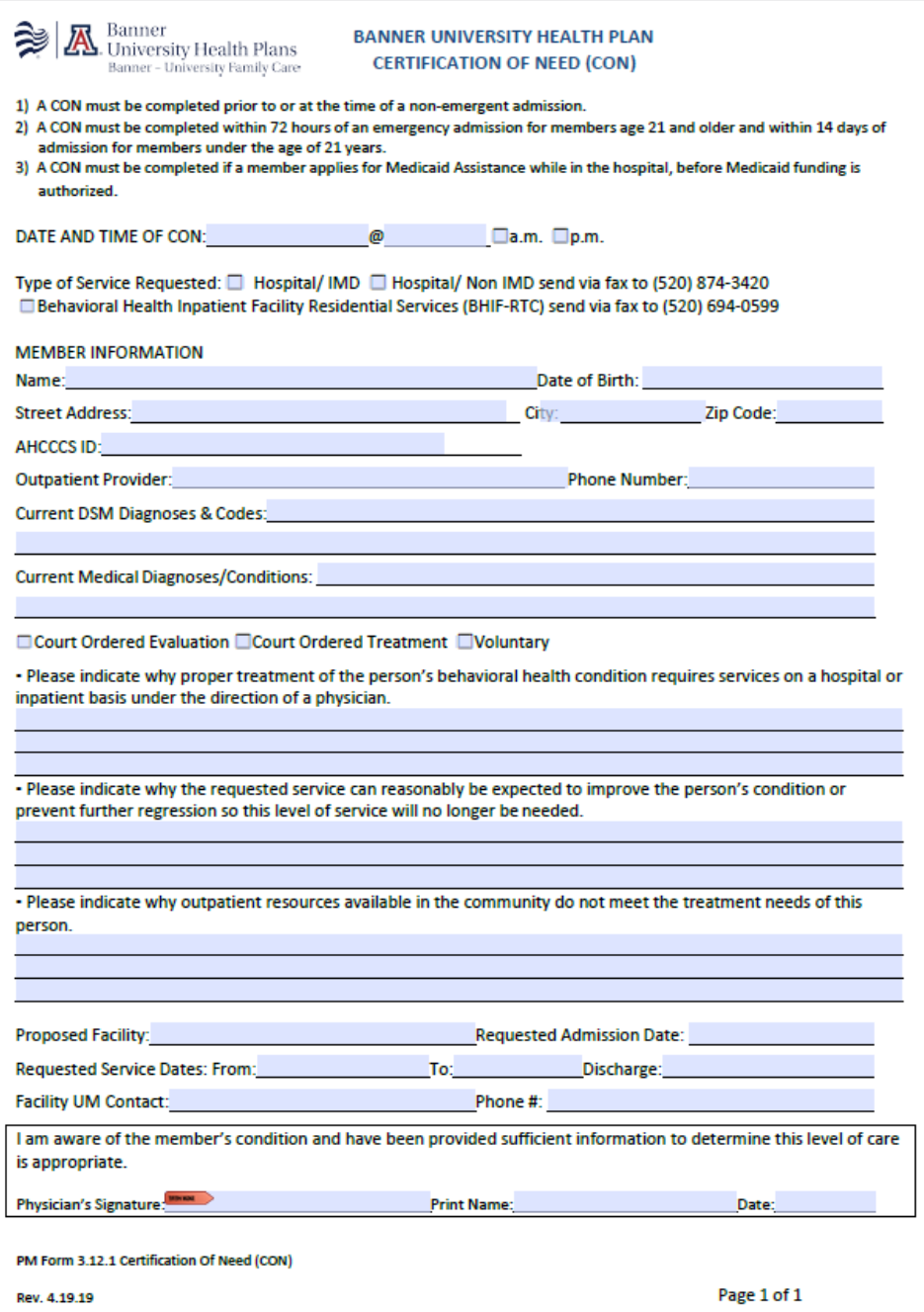
Other Forms needed

CON—Certification of Need

CON is needed for BHIF Admissions

The out patient provider BHMP is to fill out and sign off on the Certification of Need when a youth admits to BHIF.

These are due to the reviewer at the health plan within 72 hours of admission to BHIF.



Banner University Health Plans
Banner – University Family Care

BANNER UNIVERSITY HEALTH PLAN
CERTIFICATION OF NEED (CON)

1) A CON must be completed prior to or at the time of a non-emergent admission.
2) A CON must be completed within 72 hours of an emergency admission for members age 21 and older and within 14 days of admission for members under the age of 21 years.
3) A CON must be completed if a member applies for Medicaid Assistance while in the hospital, before Medicaid funding is authorized.

DATE AND TIME OF CON: _____ @ _____ ☐a.m. ☐p.m.

Type of Service Requested: ☐ Hospital/ IMD ☐ Hospital/ Non IMD send via fax to (520) 874-3420
☐ Behavioral Health Inpatient Facility Residential Services (BHIF-RTC) send via fax to (520) 694-0599

MEMBER INFORMATION
Name: _____ Date of Birth: _____
Street Address: _____ City: _____ Zip Code: _____
AHCCCS ID: _____
Outpatient Provider: _____ Phone Number: _____
Current DSM Diagnoses & Codes: _____
Current Medical Diagnoses/Conditions: _____

☐Court Ordered Evaluation ☐Court Ordered Treatment ☐Voluntary

- Please indicate why proper treatment of the person's behavioral health condition requires services on a hospital or inpatient basis under the direction of a physician.

- Please indicate why the requested service can reasonably be expected to improve the person's condition or prevent further regression so this level of service will no longer be needed.

- Please indicate why outpatient resources available in the community do not meet the treatment needs of this person.

Proposed Facility: _____ Requested Admission Date: _____
Requested Service Dates: From: _____ To: _____ Discharge: _____
Facility UM Contact: _____ Phone #: _____

I am aware of the member's condition and have been provided sufficient information to determine this level of care is appropriate.

Physician's Signature: _____ Print Name: _____ Date: _____

PM Form 3.12.1 Certification Of Need (CON)
Rev. 4.19.19

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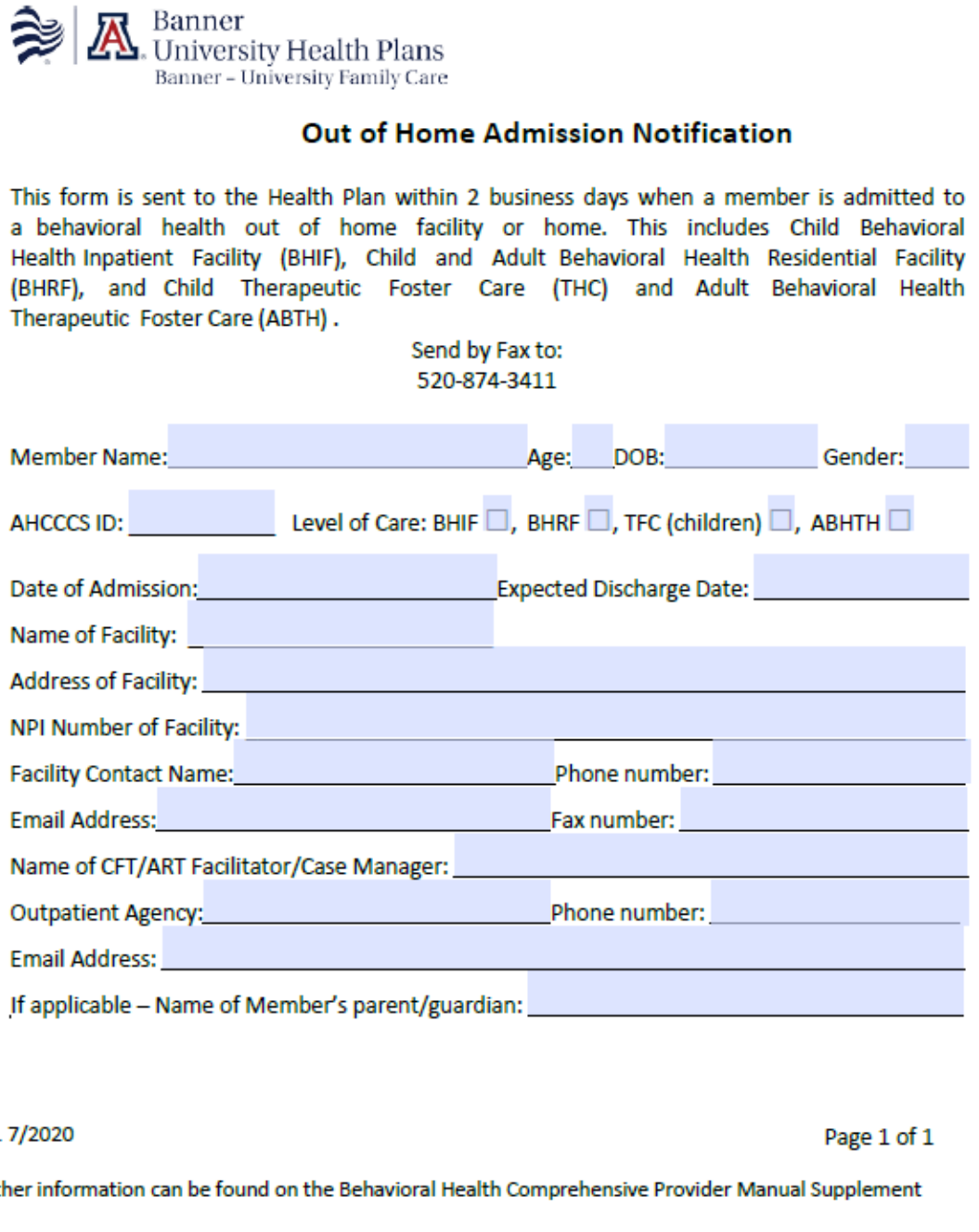
Banner Health

Other Forms needed

Out of Home Admission Notification form

Out of Home Admission Notification form

- The out of home provider is to submit the out of home admission notification form within **2 business days** of the admission.
- If it is sent after that time, the **authorization will not start until the day it is received.**
- This form was updated recently to include the NPI number of the specific home/facility. This will help claims to pay more timely and without error.



Banner University Health Plans
Banner – University Family Care

Out of Home Admission Notification

This form is sent to the Health Plan within 2 business days when a member is admitted to a behavioral health out of home facility or home. This includes Child Behavioral Health Inpatient Facility (BHIF), Child and Adult Behavioral Health Residential Facility (BHRF), and Child Therapeutic Foster Care (THC) and Adult Behavioral Health Therapeutic Foster Care (ABTH) .

Send by Fax to:
520-874-3411

Member Name: Age: DOB: Gender:

AHCCCS ID: Level of Care: BHIF ☐, BHRF ☐, TFC (children) ☐, ABHTH ☐

Date of Admission: Expected Discharge Date:

Name of Facility:

Address of Facility:

NPI Number of Facility:

Facility Contact Name: Phone number:

Email Address: Fax number:

Name of CFT/ART Facilitator/Case Manager:

Outpatient Agency: Phone number:

Email Address:

If applicable – Name of Member's parent/guardian:

Rev. 7/2020

Page 1 of 1

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

Banner Health

Other Forms needed

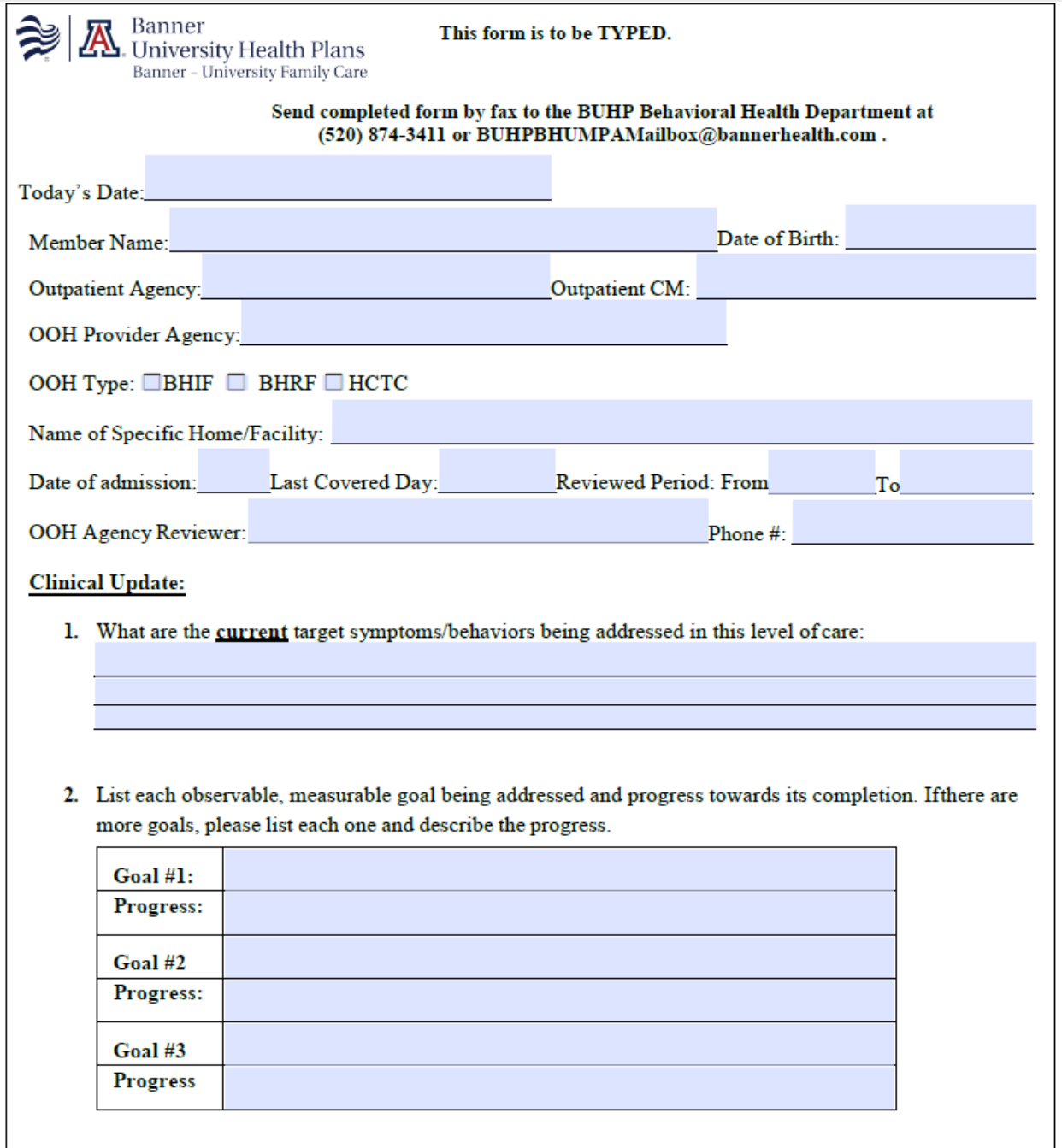
Out of Home Concurrent Review form

Out of Home Concurrent Review form

Page 1

This form is to be filled out by the UM person at the out of home provider agency or by the OOH provider clinician who can speak to the specific progress and interventions.

This form is being updated soon. Be sure you obtain the form from the website.



Banner University Health Plans
Banner – University Family Care

This form is to be TYPED.

Send completed form by fax to the BUHP Behavioral Health Department at (520) 874-3411 or BUHPBHUMPAMailbox@bannerhealth.com .

Today's Date:_____

Member Name:_____ Date of Birth: _____

Outpatient Agency:_____ Outpatient CM: _____

OOH Provider Agency:_____

OOH Type: ☐BHIF ☐ BHRF ☐ HCTC

Name of Specific Home/Facility: _____

Date of admission:_____ Last Covered Day:_____ Reviewed Period: From_____ To_____

OOH Agency Reviewer:_____ Phone #: _____

Clinical Update:

1. What are the **current** target symptoms/behaviors being addressed in this level of care:

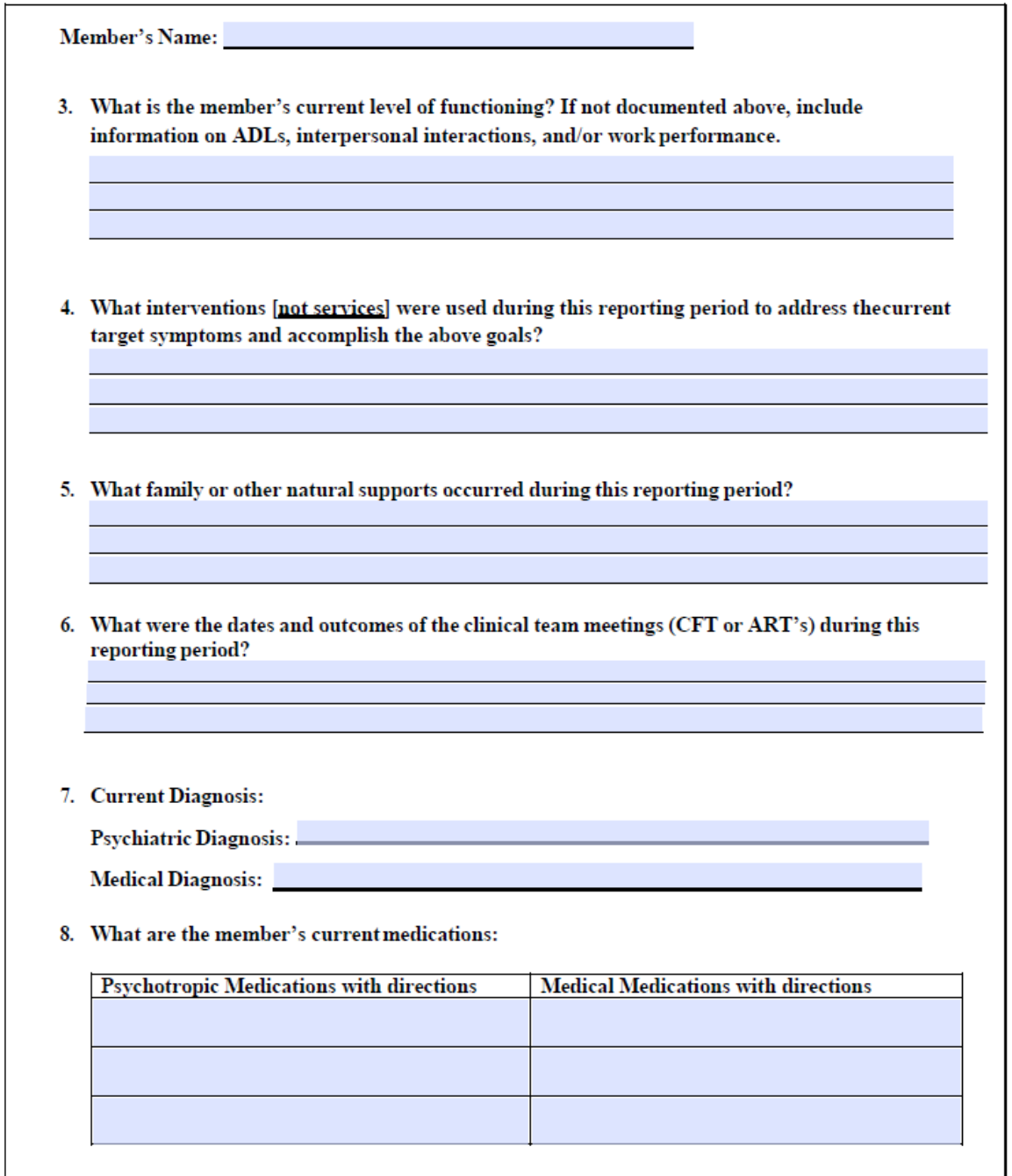
2. List each observable, measurable goal being addressed and progress towards its completion. Ifthere are more goals, please list each one and describe the progress.

Goal #1:	
Progress:	
Goal #2	
Progress:	
Goal #3	
Progress	

Out of Home Concurrent Review form

Page 2

- We need to know level of functioning/functional impairments.
- We want to know what kind of treatment are you providing? What modalities? CBT, DBT, is there a specific curriculum being utilized? We want to see evidenced based treatment modalities.



Member's Name: _____

3. What is the member's current level of functioning? If not documented above, include information on ADLs, interpersonal interactions, and/or work performance.

4. What interventions [not services] were used during this reporting period to address thecurrent target symptoms and accomplish the above goals?

5. What family or other natural supports occurred during this reporting period?

6. What were the dates and outcomes of the clinical team meetings (CFT or ART's) during this reporting period?

7. Current Diagnosis:

   Psychiatric Diagnosis: _____

   Medical Diagnosis: _____

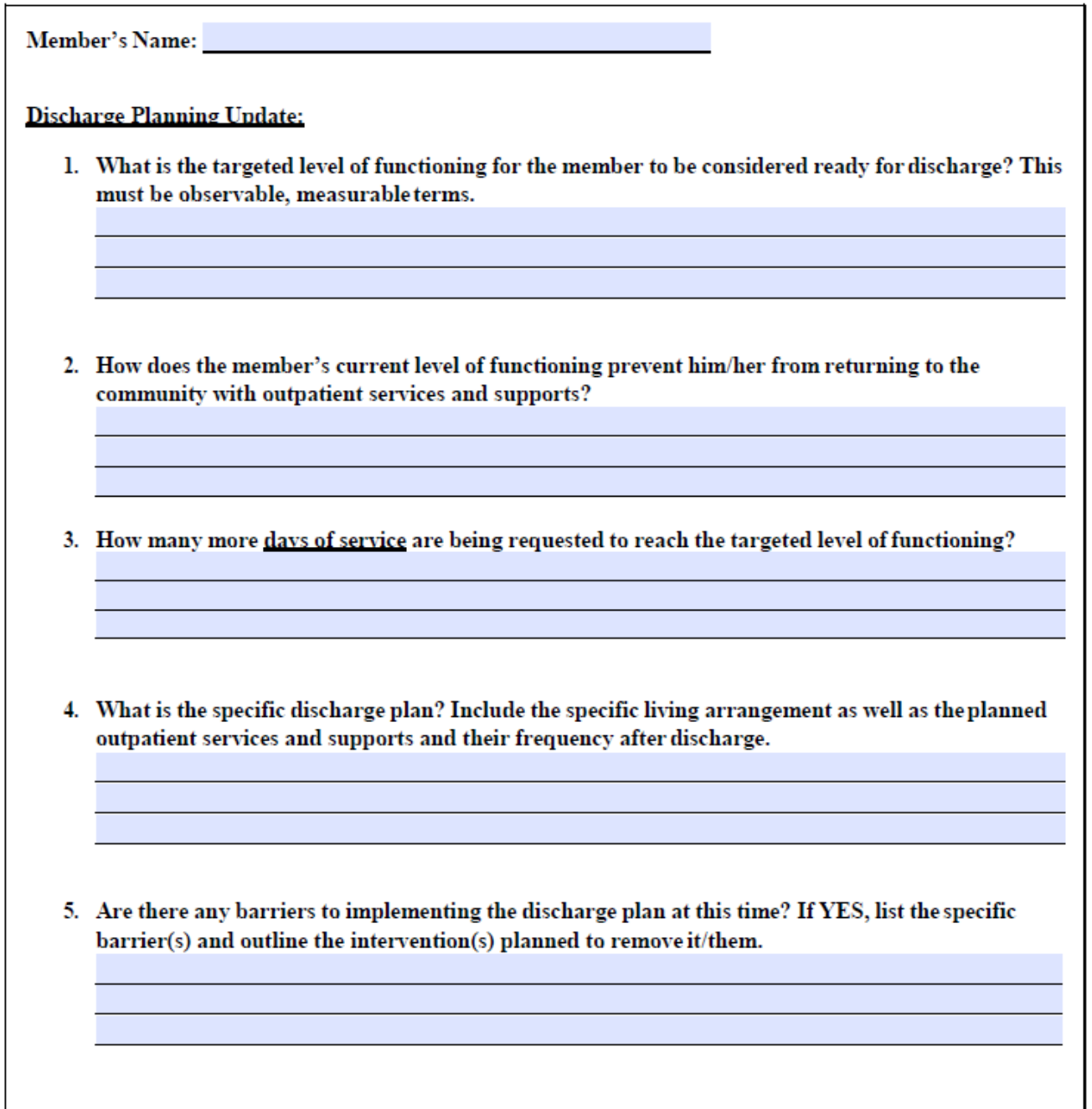
8. What are the member's current medications:

Psychotropic Medications with directions	Medical Medications with directions

Out of Home Concurrent Review form

Page 3

- How will everyone know when this member is ready to discharge? What will they be demonstrating so everyone knows they are ready? Remember that behaviors are not likely to be gone completely, but can be reduced to a manageable level.
- Why can't member DC yet?
- We need the specific DC plan.



Member's Name: _____

Discharge Planning Update:

1. What is the targeted level of functioning for the member to be considered ready for discharge? This must be observable, measurable terms.

2. How does the member's current level of functioning prevent him/her from returning to the community with outpatient services and supports?

3. How many more days of service are being requested to reach the targeted level of functioning?

4. What is the specific discharge plan? Include the specific living arrangement as well as the planned outpatient services and supports and their frequency after discharge.

5. Are there any barriers to implementing the discharge plan at this time? If YES, list the specific barrier(s) and outline the intervention(s) planned to remove it/them.

Banner Health

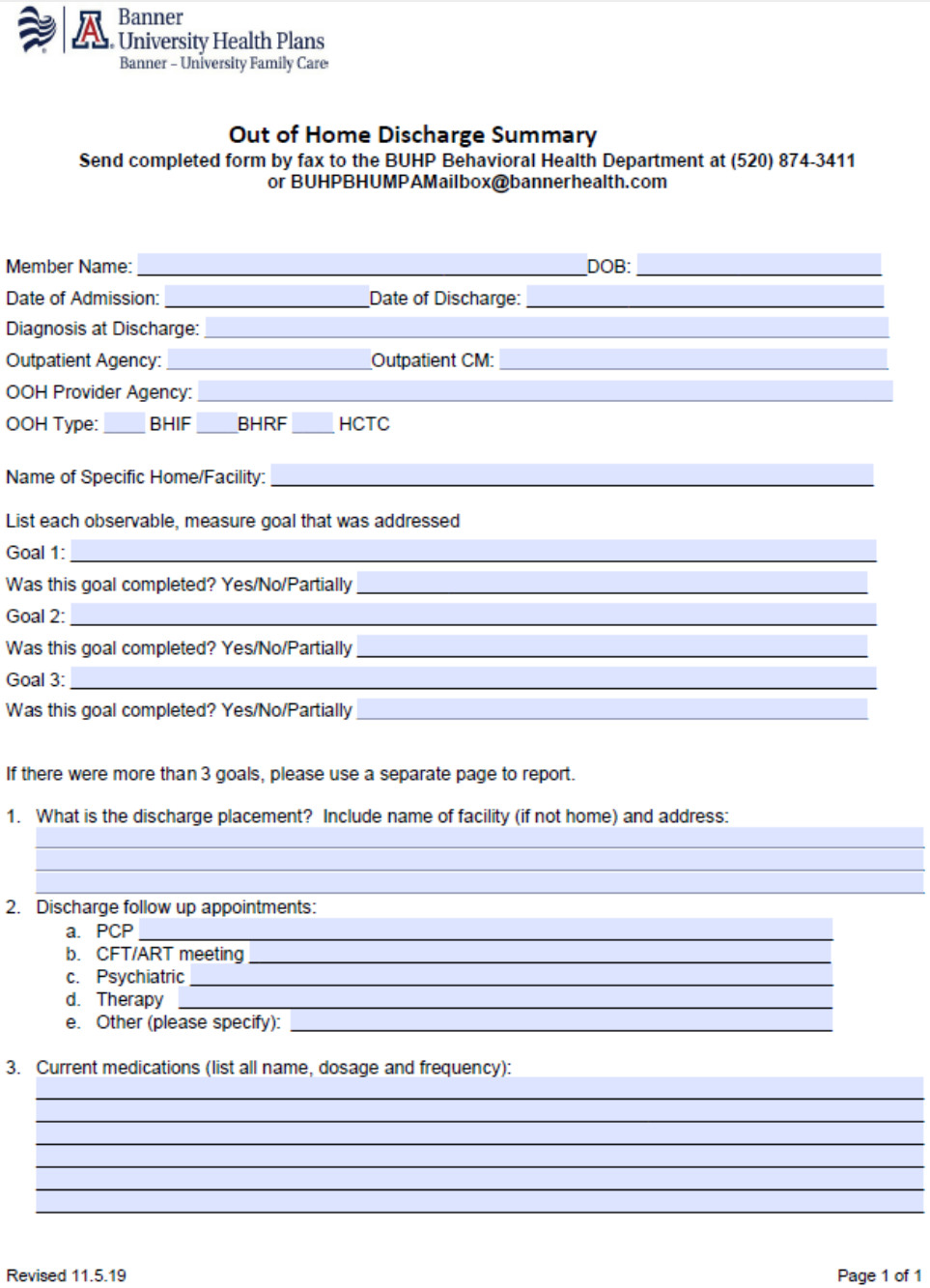
Other Forms needed

Out of Home Discharge Summary Form

Out of Home Discharge Summary

This is NOT required IF the OOH program has their own DC summary AND if all of the elements on this form are included. If not, please use this form.

Discharge forms are due within 24 hours of DC from all levels of care.



Banner University Health Plans
Banner – University Family Care

Out of Home Discharge Summary

Send completed form by fax to the BUHP Behavioral Health Department at (520) 874-3411 or BUHPBHUMPAMailbox@bannerhealth.com

Member Name: _____ DOB: _____

Date of Admission: _____ Date of Discharge: _____

Diagnosis at Discharge: _____

Outpatient Agency: _____ Outpatient CM: _____

OOH Provider Agency: _____

OOH Type: ____ BHIF ____ BHRF ____ HCTC

Name of Specific Home/Facility: _____

List each observable, measure goal that was addressed

Goal 1: _____

Was this goal completed? Yes/No/Partially _____

Goal 2: _____

Was this goal completed? Yes/No/Partially _____

Goal 3: _____

Was this goal completed? Yes/No/Partially _____

If there were more than 3 goals, please use a separate page to report.

1. What is the discharge placement? Include name of facility (if not home) and address:
2. Discharge follow up appointments:
   a. PCP _____
   b. CFT/ART meeting _____
   c. Psychiatric _____
   d. Therapy _____
   e. Other (please specify): _____
3. Current medications (list all name, dosage and frequency):

Revised 11.5.19

Page 1 of 1

Questions?

Thank you for your time today!

Beth Pfile and Lynda Crooms

Beth.pfile@bannerhealth.com and Lynda.Crooms@bannerhealth.com