UniCare
An Anthem Company

UniCare Health Plan of West Virginia, Inc.
Mountain Health Trust

Behavioral Health Authorization Request

UniCare Health Plan of West Virginia, Inc. (UniCare) contact information:

- Behavioral Health phone: **1-866-655-7423**
- Fax (inpatient): **1-855-325-5556**
- Fax (outpatient): **1-855-325-5557**

To prevent a delay in processing your request, please fill out the form in its entirety with all applicable information.

Today's date:	Provider return fax:	
Member information		
First name:	Last name:	
UniCare member ID:		
Address:		
City:	State:	ZIP code:
Date of birth:	Contact phone:	
Parent/guardian name:	Contact phone:	
Does the member have additional health insurance?: ☐ Yes ☐ No		
If yes, please provide additional information:		
Referring provider: ☐ Contracted ☐ Noncontracted **(Complete the below box if individual provider is not billing.)**		
Full name:	Specialty:	
NPI:	TIN:	
Office contact name:		
Office phone:	Office fax:	
Address:		
City:	State:	ZIP code:

Servicing provider: ☐ Contracted ☐ Noncontracted (Complete the below box if individual provider is billing.)		
Full name:	Specialty:	
NPI:	TIN:	
Office contact name:		
Office phone:	Office fax:	
Address:		
City:	State:	ZIP code:

Servicing facility: ☐ Contracted ☐ Noncontracted (Complete the below box if the facility is billing.)		
Full name:	Specialty:	
NPI:	TIN:	
Office contact name:		
Office phone:	Office fax:	
Address:		
City:	State:	ZIP code:
Discharge planner name:	Contact phone:	

Requested service (for type of service, check all that apply)	
☐ Emergent: Use for all nonelective inpatient admissions only, when the member has already been admitted.	
☐ Urgent: Use when provider indicates that the service is urgent, emergent or expedited, or when the service is required to avoid a delay in discharge from an inpatient admission.	
☐ Elective: Use for routine services.	
☐ Initial authorization ☐ Extension request	
Admit/start date:	
Existing UM number:	Current days authorized:

Additional information		
☐ Episode of care	☐ Court ordered	
Please submit all appropriate clinical information, provider contact information and any other required documents with this form to support your request. If this is a court-ordered request, please include a copy of the court order with the request.		
ICD-10-CM diagnosis code(s) **(Enter primary and any applicable co-occurring ICD-10-CM diagnosis codes.)**		
1.	2.	3.
4.	5.	6.
CPT® code(s) (Include requested units.)		
1.	2.	3.
4.	5.	6.
Has the member exceeded allowed units for any codes listed above? ☐ Yes ☐ No		
Place of service: ☐ Inpatient hospital ☐ Psychiatric residential treatment ☐ On-campus outpatient hospital ☐ Community mental health center ☐ Office ☐ Other		
Type of service: ☐ Crisis stabilization ☐ Intensive outpatient service ☐ Partial hospitalization program ☐ Professional services ☐ Psychiatric ☐ Residential psychiatric treatment ☐ Other		
Precipitant to admission		
Why is this level of care needed now?		
Include medical necessity for this level of care:		
Current legal issue:		
Previous treatment:		

Current treatment plan with SMART goals (S — specific, M — measurable, A — achievable, R — relevant, T — time-bound):
Standing medications:
As-needed (PRN):
Other treatment and/or interventions planned — SMART goals:
Summary of family therapy (date, time, participants, outcome):
Support system
Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone number and case number.
Readmission within last 30 days
Has the member been readmitted in the last 30 days? ☐ Yes ☐ No
If yes and readmission was to the discharging facility, what part of the discharge plan did not work and why?

Discharge plan		
Can member return to current residence? ☐ Yes ☐ No		
Discharge plan (please include changes, barriers and plan of care to resolve barriers):		
Follow-up appointments		
Dates:	Times:	Providers:
Signature of staff completing the form:		
Name (please print):		
Signature/credential:		Date: