PerformCARE®

Prior Authorization for Substance Use Disorder Out of Network (OON)

Member Name: _____ **Member MAID# (10 digits):** _____

Member DOB : _____ **Member Phone:**_____

Member Address: _____

Provider Name: _____ **(as credentialed with PerformCare)**

Provider Service Address: _____

City, State, Zip: _____

Contact Person: _____**Phone:** _____ **Fax:**_____

Signed Release for PerformCare?
Offered Provider Choice?
Communication with PCP or other relevant health practitioners about treatment?
Communication with PCP or other relevant health practitioners about treatment?
If No, did member refuse?

Other Insurance: Name and Policy Numbers:

Reason Other Insurance Not Used:

DIAGNOSIS CODES:	

90791 Diagnostic Interview

Name and Credentials (degree):	Start Date:	☐ HO Masters	☐ HP Doctoral

CPT Code	Start Date	If Reauthorization- # used-Prior Auth	Description	Units (Minutes)	Units Issued
H0015			Intensive Outpatient		280 (4 weeks)
H0020			Methadone		365
90834			Individual Psychotherapy		15
Other:					

ASAM Dimensions	Level of Care	Criteria Indicated	
Dim. 1 Acute Intoxication/Withdrawal Potential			
Dim. 2 Biomedical Conditions and Complications			
Dim. 3 Emotional/Behavioral/Cognitive			
Dim. 4 Readiness to Change			
Dim. 5 Relapse/Continued use/Continued Problem Potential			
Dim. 6 Recovery/Living Environment			

PerformCARE®

OON GENERAL INFORMATION FORM
(Please submit with OON Request Form)

Name of Contracting Provider:	
Corporate Address:	
Corporate Mailing Address: (if different)	
Billing and Claims Address: (if different)	
Executive Director/CEO: (Name and Title)	
Contact Person for this Contract: (Name and Title)	
Telephone Number: Fax: Email address: After-hours phone number:	
Quality Department Contact Name: Phone Number: Email:	

ACCREDITATION AND LICENSES

1. Do you hold any national accreditations? Please check all that apply.

☐ CARF ☐ JCAHO ☐ NCQA ☐ HRS/OLC ☐ OTHER:

(Please include copy of certificate)

2. PA Licensure: ☐ Yes ☐ No If yes, specify licensing agency (s) below.

Please list all that apply related to this agreement. Include copies of current licenses.

Licensing Authority	Licensed Services

3. Medical Assistance Identification Number and Provider Type:
4. NPI Number that will be used for billing:
5. Tax I.D. Number (Provide W-9):