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Prior Authorization for Mental Health Out of Network Request Form

Member Information

Member Name: _____ MAID: _____ DOB: _____

Member Address: _____ Phone #: _____

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Provider Information

Therapist Name (including credentials): _____

Provider Name for Authorization: _____

Service Address: _____ Phone #: _____

Person Completion Form: _____

Please complete the following:

Other insurance (name/Policy #): _____

Reason other insurance not used: _____

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Authorization

Diagnosis codes: _____

Code	Description	Start Date	Units (Minutes)	Units Issues
90791	Diagnostic Interview ☐ HO Masters ☐ HP Doctoral			
90834	Individual Psychotherapy			60
90847	Family Psychotherapy with Member			240
90846	Family Psychotherapy without Member			240
90853	Group Psychotherapy			480
	Other: _____			
	Other: _____			

Detailed rationale for utilizing an OON Provider including why an INN Provider is unable to meet the Member's treatment needs (request will not be processed without this information):

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

Name of contracting provider:	
Service address:	
Mailing address: (if different)	
Billing and claims address: (if different)	
Tax 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:	
Is this location smoke free?	☐ Yes ☐ No
Is this location handicap accessible?	☐ Yes ☐ No

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 applies 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):

Out of Network Provider Resource

NETWORK OPERATION RESOURCES:

- CLAIMS TRAINING: https://pa.performcare.org/assets/pdf/providers/education-training/claims-submission-overview.pdf
    - OON providers are permitted and high encouraged to submit claims electronically, paper claims are not required.
- ADMINISTRATIVE APPEAL: https://pa.performcare.org/providers/claims-billing/admin-appeals.aspx
- CLAIMS CONTACT CENTER: 1-888-700-7370 Option 1, 8am-4:30pm Monday-Friday
- PROVIDER MANUAL: https://pa.performcare.org/assets/pdf/providers/resources-information/provider-manual.pdf
- WANT TO BECOME AN IN-NETWORK PROVIDER: https://pa.performcare.org/providers/resources-information/contact-network-operations-credentialing.aspx
- Sign up for iContact alerts: https://pa.performcare.org/apps/icontact-networknews/index.aspx

CLINICAL & QUALITY IMPROVEMENT RESOURCES:

- CRITICAL INCIDENT REPORTING: https://pa.performcare.org/providers/quality-improvement/critical-incident-reporting.aspx
- RESTRAINT and SECLUSION REPORTING: https://pa.performcare.org/providers/quality-improvement/restraint-seclusion-monitoring.aspx
    - Critical incidents and reports of restraint and seclusion must be reported to PerformCare within 24 hours of the occurrence.
- Upon identification of a quality-of-care concern, the PerformCare Quality Improvement Department may request to review a Member's record and/or request the completion of corrective action to address the concern.
- CLINICAL POLICIES & PROCEDURES (P&P): PerformCare P&Ps can be found on the PerformCare website: https://pa.performcare.org/providers/resources-information/policies.aspx. All providers should follow all P&Ps related to their specific level of care.
- UM CONTINUED STAY REVIEW PROCESS (MH IP, MH PHP, SUD): Providers must outreach to PerformCare UM CCM to coordinate a live/telephonic review that will on the last covered day and a live/telephonic discharge review to occur within two business days of the member leaving treatment.
    - Name/Contact information for the IP UR Contact completing continued stay and discharges should be communicated at time of prior auth to facilitate coordination
- FORMS (FBMHS, IBHS, CRR AND RTF): https://pa.performcare.org/providers/resources-information/forms.aspx
    - Requests for Children's Services should be faxed, using a submission sheet, to 1-855-707-5823
- Pennsylvania State 3800 Regulations for RTF: http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/chapter3800/chap3800toc.html&d
- CLINICAL INFORMATION FOR CHILD/ADOLESCENT TREATMENT TEAM MEETINGS*:* review of individual therapy goals and progress, family therapy goals and progress, family members attending sessions and frequency of sessions, family engagement and discussion of therapeutic leaves, community integration opportunities while in RTF/OTHER LOC, current educational setting and accommodations, restraints or critical incidents, crisis planning, and discharge planning.

Please contact PerformCare at **888-700-7370** if you have questions about any of the above topics. Our Provider services (MSS) department can direct your call to the appropriate department for support which includes, but is not limited to: Provider Claims Services, Quality Improvement/Complaints & Grievances Department, Clinical Department and Provider Relations. Thank you!