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Substance Use Out-of-Network (OON) Prior Authorization 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: _____

Provider Address: _____ Phone #: _____

Person Completing Form: _____

Please complete the following sections if they are applicable:

Other insurance (name/Policy #): _____

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Reason other insurance not used: _____

Date Member started with Provider and funding source, including the reason funding source ended. (example: Member started with Provider on 12/1/24 under insurance BC/BS, however that insurance ended 12/15/24 and PerformCare is only current insurance for behavioral health services).

Reason for OON request: Check All that Apply.

☐ Member has a need for limited specialty practice not currently available in the network.
Provide detailed explanation of behaviors and specialty.

☐ Member's behavioral health would be jeopardized by requiring the Member to relocate to an in-network Provider for services.
Provide detailed explanation of behaviors and reason for going to OON Provider.

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☐ Member recently became enrolled in PerformCare and the Provider currently serving the Member is in the process of becoming credentialed and contracted with PerformCare. Provide date active with PerformCare and detailed explanation of behaviors and reason for need to be seen ONN instead of current INN Provider.

☐ Member had TPL and TPL no longer active and PerformCare is now Primary. Provide Date TPL ended, Name of TPL, date when Member started service with Provider and detailed explanation of behaviors and reason for need to be seen ONN instead of current INN Provider.

☐ Member moved to PerformCare County and PerformCare is now Primary. Provider date of move, date when Member started service with Provider and detailed explanation of behaviors and reason for need to be seen ONN instead of current INN Provider.

☐ Other. Provide detailed explanation of behaviors and reason for going to OON Provider

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Authorization

Diagnosis codes: _____

☐ Initial Request ☐ Reauthorization Request (# used in prior auth: _____)

Code	Description	Start Date	Units (Minutes)	Units Issues
H0015	Intensive Outpatient Program			1976 (6 months)
H0020	Methadone			365
90832	**Individual Psychotherapy 30 min**			60
90834	Individual Psychotherapy 45 min			60
90837	Individual Psychotherapy 60 min			60
	Other: _____			
	Other: _____			

ASAM Dimension	LOC Indicated	Criteria indicated and/or comment
Dimension 1: Acute Intoxication or Withdrawal Potential		
Dimension 2: Biomedical Conditions and Complications		
ASAM Dimension	LOC Indicated	Criteria indicated and/or comment
Dimension 3: Emotional/Behavioral/Cognitive		
Dimension 4: Readiness to Change		
Dimension 5: Relapse/Continued Use/Continued Problem Potential		
Dimension 6: Recovery/Living Environment		

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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
Is this a home office?	☐ Yes ☐ No
Are you providing telehealth?	☐ Yes ☐ No (If yes, must be in compliance with OMHSAS 22-02)

ACCREDITATION AND LICENSES

1. Do you hold any national accreditations? Please check all that apply. (Please include copy of certificate)

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

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!