**Thurston Mason BH-ASO Non-Medicaid ITA Notification of Service Form**

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|  **PATIENT DEMOGRAPHICS**  |

Patient Full Name:       Date of Birth:       P1 ID, if applicable:       SSN:       Gender:

Street Address:       City:       Zip Code:

County of Residence:

**Involuntary Psych IP ordered by*:*** [ ]  Court [ ]  DCR [ ]  Other:       **County of Detainment**:       - **Please** **include detainment documents.**

Length of Current ordered hold:       Start Date:       Next Court Date:       **Expected Length of IP Stay**:      Days

**Prior Authorization?** [ ] , or **Retro Authorization?** [ ]  **Date** **&** **Time** of request:

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| **PROVIDER INFORMATION** |

**Date & Time** of Patient Admit       Provider Agency Name:       Provider Agency NPI:       Provider Location:

Facility UR Name:       Phone:       Fax:       Email:

Attending Treatment Psychiatrist/Physician Name:

Date & Time of last known Mental Health and/or Substance Use Disorder (SUD) Assessment:

Can a Behavioral Health diagnosis be determined?[ ] Yes [ ] No

ICD-10 Code & DSM-5 Primary Diagnosis       ICD-10 Code & DSM-5 Secondary Diagnosis

Psychiatric Medications:

Tox Screen Completed? [ ] Yes [ ] No Tox Screen result:       BAL result:

Comorbid (Medical or Substance Use): [ ] Yes [ ] No

ASAM Level, if applicable:

**Current Primary presenting issue:**

**Treatment Plan Summary:**

Risk Assessment Completed?[ ] Yes [ ] No – If yes, please include with Notification form.

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|  **BENEFIT INFORMATION**  |

**Medicaid Application status?**

[ ]  Pending **– If so, what date was application submitted?**

[ ]  Not yet applied – **If so, please explain why.**

[ ]  Not eligible – **If not eligible, please explain why.**       **Please submit supporting documents showing ineligibility.**

**Is the patient on a Spenddown?** [ ] Yes [ ] No – If yes, what is the total amount?

**Other Benefit Plan**: [ ] Medicare – Bed Days Remaining:       [ ] Commercial/Other – Benefit Name?       [ ] None

Benefit contacted for Authorization? [ ] Yes [ ] No Comments:

Request Results:       Benefit Contact Name:       Phone:       Fax:       Email:

**Please submit determination documentation from other benefit with this form. (Required to receive payment from TMBH-ASO)**

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|  **REQUEST FORM INSTRUCTIONS** |

* **Thurston Mason BH-ASO reserves the right to deny authorization requests that do not meet our state-directed policy for timely Non-Medicaid ITA authorizations.**
* Notification to Thurston Mason BH-ASO is **required** for all Involuntary Non-Medicaid admissions requests within **24 hours of admission.**
* Continued stay requests are due **24 hours prior to the end date** of current authorized length of stay using our **Concurrent Review Form**.
* This form should be filled out electronically. Handwritten forms may be sent back without authorization.
* **Discharge summaries** are **required** to be faxed into TMBH-ASO at: 360-489-1435 or emailed securely to iprequest@tmbho.org.
* Discharge summaries are required to receive any payment from TMBH-ASO.

Please send **fully completed** form and **all required** documents via **Encrypted** email to: iprequest@tmbho.org.

TMBH-ASO will reply to request emails with an Authorization number or report a determination to the listed UR Email above the following business day.

Questions? Contact us at: Main Line: 360-763-5828 or UM Specialist: 360-763-5805

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| **ADDITIONAL (SECURE DETOX ONLY) REQUIRED INFORMATION** |
| **FEMALE ONLY** – Pregnant or Parenting Child Under Age 18 Years Old?[ ]  (Y) Yes [ ]  (N) No[ ]  Refused [ ]  Unknown | If Pregnant,Due Date:      | Medication Assisted Opioid Treatment:[ ]  (Y) Yes [ ]  (N) No[ ]  Not applicable[ ]  Unknown[ ]  Not collected | Used Needle Recently (Last 30 days):[ ]  Yes[ ]  No | Enrolled in Drug Court:[ ]  (Y) Yes[ ]  (N) No |
| Treated For Substance Abuse Problem In The Past?:[ ]  (Y) Yes [ ]  (N) No | 🡨 If “Yes”, document Location and Dates of Treatment:      |
| Anyone In Your Family Have A Substance Abuse Problem?:[ ]  (Y) Yes [ ]  (N) No | 🡨 If “Yes”, comment or N/A:      |
| **Income Source:**[ ]  Wages/Salary [ ]  Public Assistance [ ]  Retirement/Pension [ ]  Disability [ ]  Other [ ]  None [ ]  Not collected  |  |
| **SUBSTANCE USE - KEY CODES USED BELOW** |
| **Frequency of Use/Peak Use** | **Method** |
| Code | Definition | Code | Definition |
| 1 | No Use | 1 | Inhalation |
| 2 | 1-3 Times In A Month | 2 | Injection |
| 3 | 4-12 Times In A Month | 3 | Oral |
| 4 | 13 or More Times In A Month | 4 | Other |
| 5 | Daily | 5 | Smoking |
| 6 | Not Applicable |  |
| **Substances** |
| **Code** | **Definition** | 11 | Other Stimulants |
| 1 | None | 12 | Benzodiazepine  |
| 2 | Alcohol | 13 | Other non-Benzodiazepine Tranquilizers |
| 3 | Cocaine/Crack | 14 | Barbiturates  |
| 4 | Marijuana/Hashish  | 15 | Other Non-Barbiturate Sedatives or Hypnotics |
| 5 | Heroin | 16 | Inhalants  |
| 6 | Other Opiates And Synthetics  | 17 | Over-The-Counter  |
| 7 | PCP-phencyclidine | 18 | Oxycodone |
| 8 | Other Hallucinogens  | 19 | Hydromorphone |
| 9 | Methamphetamine | 20 | MDMA (ecstasy, Molly, etc) |
| 10 | Other Amphetamines  | 21 | Other |
| Report History of Specific Substance Use With the Above Key Codes Ranked in Relative Importanceas provided by the client and determined by the counselor.If there is no secondary or tertiary Substance, then report “None (1)” for Substance Code and leave the remaining fields blank. |
|  | Substance (Code) | Age at First  | Method (Code) | Date Last Used  | Use Amount  | Frequency of Use (Code) Last 30 Days | Peak Use (Code) |
| Primary (1) |       |       |       |       |       |       |       |
| Secondary (2) |       |       |       |       |       |       |       |
| Tertiary (3) |       |       |       |       |       |       |       |