Behavioral Health Care Management Mental Health and/or Substance Use Treatment Request

2650 Novation Parkway
Fitchburg, WI 53713
(800) 683-2300
Fax (608) 471-4391
QuartzBenefits.com

Please write clearly and legibly. Complete all sections.
See accompanying instructions on pages 2 and 3.

Member information

Name:	Date of birth:
Quartz insurance ID number:	Admit date (if already admitted):

Referral source/requesting clinician

Provider name:	Phone:	Fax:
Facility/clinic name:	Last date seen by referring provider:	

Requested treatment provider information

Facility name:	Provider name:

Facility address:

Contact name:	Phone:	Fax:

Type of service being requested
Include procedure HCPCS codes being requested.

☐ Inpatient rehabilitation/detox ☐ Residential ☐ PHP ☐ IOP ☐ Outpatient

Procedure/HCPCS code(s) for requested service(s):

Start date of service:

DSM-5/ICD-10 codes and description

Code(s):	Description:

Problem description

Provide detailed information on the situation, symptoms, and functioning that directly led to the current request for services. Include with this form additional documentation such as a biopsychosocial assessment, MD notes, assessment scores, outpatient treatment plan, ASAM or other placement criteria if applicable, and/or any other clinical information supporting the requested services.

Instructions for Behavioral Health Care Management Mental Health and/or Substance Use Treatment Request

Member information

Name and date of birth: Include the correct spelling of the member's name and date of birth. Accurate information is crucial for the timely processing of the request.

Quartz insurance ID number: This is the member's insurance ID number. It is okay to leave it blank if you don't have this information.

Admit date: Complete if the member has already been admitted to the requested treatment services.

Referral source/requesting clinician

Provider name, facility/clinic name, phone, and fax: This is the name of the provider/facility completing the form. Include the phone number and fax number.

Last date seen by referring provider: Include the last date seen by the provider completing this form.

Requested treatment provider information

Facility name and provider name: This is the provider/facility/program to which the member is referred. Include both if you have them. If you only know the program/facility you're referring to, put that information in this space.

Facility address: If this is a Quartz in-network provider, include the city name for the location. Please include the facility's address if this is an out-of-network location (non-Quartz provider).

Contact name, phone, and fax: If you are a facility/program making an internal referral, please complete this information for the requested treatment program. If you are referring to a provider/program outside of your facility, it is okay to leave it blank.

Type of service being requested

Inpatient rehabilitation/detox: This level of care provides 24-hour evaluation and withdrawal management in a hospital-based inpatient program under the supervision of a physician; however, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. Inpatient rehabilitation is considered a Level 3.7 by the American Society of Addiction Medicine.

Residential: This level of care is also referred to as clinically managed high-intensity residential services and is a Level 3.5 by the American Society of Addiction Medicine. Services are provided 24 hours a day, seven days a week, in a health care facility licensed for residential substance use disorder treatment.

Partial Hospital Program (PHP): This is a time-limited, ambulatory treatment program offered during the day or evening. PHP is often referred to as day treatment or acute day hospital. It offers at least 20 hours of clinically intensive programming within a licensed health care facility and is considered a Level 2.5 (High Intensity Outpatient) by the American Society of Addiction Medicine.

Intensive Outpatient Program (IOP): This program is offered in the day or evening and can be a step down from a more restrictive level of care or a step up to prevent the need for a more restrictive level of treatment. The American Society of Addiction Medicine considers it Level 2.1. Treatment is a minimum of 9 hours per week.

Outpatient: This request is used for outpatient psychotherapy or medication management. A prior authorization is only required if the request is for services with an out-of-network provider.

DSM-5/ICD-10 codes and description

Code(s) and description: Provide specific codes and any subtypes and/or specifiers.

Problem description

Problem description: Provide detailed information about the situation, symptoms, and functioning that directly led to the current request for services. Evidence-based medical necessity guidelines will be applied using the clinical information included in this request.