SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

PROVIDER - Send to
HS_BHRS_ACCESS_UM@smcgov.org
Or fax (650) 596-8065

ACCESS UM PRIOR AUTHORIZATION REQUEST FORM

* Requests should be submitted to ACCESS **5 days prior** to the end date of previous utilization period.

Date _____ **Program Provider** _____ **Provider #** _____

Client Name _____ **DOB** _____ **MH#** _____ **Client Admit Date** _____

AUTHORIZATION HISTORY (For Re-Authorization ONLY)

Previous Auth	Auth Start Date	Auth End Date	Total Number Claimed: ☐ Units ☐ Hours ☐ Days
Authorization 1			
Authorization 2			
Authorization 3			
Authorization 4			

AUTHORIZATION REQUEST FOR SERVICES (to be completed by Provider/ Referring Clinician)

Period requested: Start Date_____ End Date _____

NO.	CPT Codes or Service Type	Number Requested: ☐ Units ☐ Hours ☐ Days
1		
2		
3		
4		
5		
6		

Clinical Justification/ Progress Summary
(for initial auth request **/** for re-auth, see guide on page 2)

_____ _____ _____ _____
Requesting Staff Signature License No | Supervisor Signature | Date of Request | Contact information

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

To Be Completed by San Mateo County Access UM Team

REQUEST DISPOSITION:

Request Receipt Date _____

☐ Services are approved for # _____ ☐ Units _____ ☐ Hours ☐ Days

Authorization Period: Start Date _____ End Date _____

☐ Additional documentation or information is requested: _____

☐ Services Request Modified/ Partially Approved – NOABD/IDN required

☐ Services Request Denied – NOABD/IDN required

☐ Services Request Referred/Redirected – Delivery System NOABD/IDN required

Comments/Reason for Approval/ Denial:

_____ _____

Authorizing Access UM Staff Signature/Printed Name (LPHA only) Date of Decision

TBS

Identify the specific behaviors and/or symptoms that jeopardizes continuation of the current placement or the specific behaviors and/or symptoms that interfere with the child or youth transitioning to a lower level of care, describe progress that has been made towards TBS goals, if 3rd authorization, identify transition plan.
(upload assessments and tx plans in avatar prior to request for re-authorization)

Eating Disorder

Identify the specific symptoms that justify the continued request for authorization of level of care requested, describe efforts to coordinate care with primary mental health treatment team), describe progress and barriers to client meeting tx goals. (Attach assessment, vitals, tx plan). If 3rd authorization, describe transition plan.

ECT

Identify the reasons ECT is warranted including unmet tx goals at lower levels of care (including any medication trials) 1st authorization/referral. Indicate progress member has made to date with ECT treatment, define when ECTs will be discontinued – what changes will have occurred. Please indicate the plans for treatment and medication once ECT is completed (medical director approval needed)