South Country HEALTH ALLIANCE

Submit Fax Request to: SCHA Behavioral Health
888-633-4052 (Fax)

Dialectical Behavioral Therapy Authorization

TYPE OF REQUEST:	☐ **Initial**	☐ **Additional**

Member Information

Name:	ID Number:
Date of Birth:	Address:

Provider Information

Name:	Address:
Facility NPI:	Facility TIN:
Phone Number:	Fax Number:

Clinical Information

Date of current diagnostic assessment (DA):	Date of current functional assessment (FA):
Primary Diagnosis:	Secondary Diagnosis:

Service Information

Service Code	Modifier(s)			Units	Start Date	End Date
H2019						
H2019						

Exclusionary Services

If DBT is being provided concurrently with an exclusionary service, complete the rationale section below. Rationale should include a coordinated plan addressing length of time and expected outcome of concurrent exclusionary service provision.

- Partial Hospitalization
- Outpatient Psychotherapy
- Day Treatment

Rationale for concurrent exclusionary service. Describe medical necessity for providing concurrent DBT and partial hospitalization, day treatment, outpatient psychotherapy, psychotherapy group or inpatient hospital.

Please submit the following with this request:

- Diagnostic Assessment and Functional Assessment
- Treatment plan – individualized treatment plan that contains the following:
  - Treatment goals, treatment objectives and outcomes

***Please follow government thresholds and authorization requirements for continued services.**

Prior authorization or predetermination confirms medical necessity only and does not guarantee payment. Payment is determined at the time the claim is received and is subject to health plan exclusions and out-of-network benefits. Plan coverage must be in effect for the member at the time services are rendered.

Reset Form