HealthPartners

Mailing Address: P.O. Box 1309 Minneapolis, MN 55440-1309 **Fax number**: 952-853-8830

In-Home Therapy Prior Authorization Request Form

HealthPartners CANNOT accept a completed form via e-mail, only by fax or US mail

Name of Member to Receive Services:	**Member's Insurance #:**	**Member's DOB:**

Facility/Provider Name/Degree/License	**Phone**	**Fax**
Address:	**Tax ID**	**NPI**
Rule 29 clinic? Yes/ No Is provider Supervised? Yes/ No	**Supervisor/Degree/License**	

See In-home Coverage Criteria online at *HealthPartners – Coverage Criteria Policies*

Has the diagnostic interview (90791) taken place? Yes/ No **Date completed or scheduled**:
(IF YES, PLEASE SEND COPY OF THE DIAGNOSTIC ASSESSMENT)

Referred by: Name/Degree/Specialty/Phone:
Is this a provider currently treating the member? Yes/ No
Does the member have a county case manager? Yes/ No **Name/Phone:**

Billing Information: Circle the CPT code(s) requested: **Is this request for CTSS or psychotherapy?**

90791 90834 90837 90846 90847 90853 **Authorization Start Date:** **Frequency of visits**:

1. **Has member had a diagnostic assessment in the office over the last six months?** Yes/No
2. **Is in-home part of a discharge plan from inpatient or residential care?** Yes/No
3. **Does the member have a medical condition or agoraphobia which renders the member homebound?** Yes/No
4. **Is the member at risk for psychiatric hospitalization or residential placement due to self-injurious behavior or recent suicidal ideation or intent to injure another)?** Yes/No
5. **Has the member received psychiatric IP care in the last 24 months?** Yes/No
6. **Does the member's treating psychiatrist have an order with clinical instructions and goals for the services to take place in the member's home?** Yes/No (If yes, please attach a copy)

Current and Provisional ICD-10 Diagnosis (es)

Symptoms/behaviors/risk factors:

School/Academic problems:

CD issues:

Legal issues/Is treatment court ordered? Yes/No (If yes, send a copy of the court order & the mental health evaluation that it was based on.)

Past treatment:

Present treatment/providers/medications:

If has a current provider or treating psychiatrist, are they recommending in-home therapy? Yes/ No

Specific reasons why the care needs to be in the home and not in the office:

What is the desired outcome of in-home treatment?

How will you know that the member is ready to be seen in the office and no longer requires care in the home?

Has member had an of out-of-home placement in the past? Yes/ No **If yes, When/Where**:

Form completed by:	**Date:**	**Phone:**