

OPC LME Authorization Request Form - "If we can't read it, we can't authorize it" - Pen & Paper Version

V.022908

Client's Name:

OPC Medical Record #:

Medicaid ID #:

Last, First Middle Initial

Date of Birth: ____/____/____ Social Security #: _____
M I d I yy If client has no S.S.N., then circle: 000-00-0000

Client's County of Residence: _____

FINANCIAL INFORMATION: Private Insurance Medicare Health Choice Medicaid IPRS Have efforts been made to seek entitlements?
(Medicaid/SSI/HealthChoice, etc.) Yes No. If "Yes", then pending denied other - explain: _____

If 'No', please explain: _____

CURRENT RISK ASSESSMENT - Check one rating for each type of risk: Key: 0 = None, 1 = Ideation only; 2 = Moderate, ideation with EITHER plan or history of attempts; 3 = Severe, ideation AND plan, with intent or means; na = Not assessed

Client's Risk To Self: 0 1 2 3 na Client's Risk To Others: 0 1 2 3 na

CURRENT IMPAIRMENTS - Please select one value for each type of impairment:

Key: 0 = None, 1 = Mild or mildly incapacitating, 2 = Moderate or moderately incapacitating, 3 = Severe or severely incapacitating, na = Not assessed for this impairment

Affective Disturbances (e.g. depression/anxiety) 0 1 2 3 na Psychosis/Cognitive Problem 0 1 2 3 na
Impulse/Reckless/Aggressive Behavior 0 1 2 3 na Self-Management Problems 0 1 2 3 na
Role Problems - Social, Family, Work or School 0 1 2 3 na Substance Abuse/Dependence* 0 1 2 3 na

* Select all that apply: Alcohol Illegal drugs Prescription drugs

ASAM Dimensions - Required when consumer has substance abuse/dependence diagnosis:

1: Intoxicated/WD Potential Lo Med Hi 2: Biomedical Conditions Lo Med Hi 3: Emot/Beh/Cog Conditions Lo Med Hi
4: Readiness to Change Lo Med Hi 5: Relapse Potential Lo Med Hi 6: Recovery Environment Lo Med Hi

Describe changes in impairments since last authorization: _____

TREATMENT IN THE PAST YEAR: None Unknown Outpt. Inpatient Residential **OUTCOME:** Unk. Improved No Change Worse

Are client's family/supports involved in treatment? Yes No Has client been evaluated by a psychiatrist? Yes No

Current psych. medications: None, or List meds - _____

Treatment adherence: Non-medication - Unknown poor fair good; Psych medication - N/A Unknown poor fair good

Services currently/recently received: _____
Enter the service CODE & FREQUENCY code frequency

Reason for continued treatment: (Please select all that apply) Remains symptomatic Maintenance Other _____

PROVIDER/AGENCY: Agency Name & Location (if more than one): _____

Name of Requestor: _____ Position: _____

Email: _____ Ph: _____ x _____ Fax: _____

DIAGNOSES Include the Numeric Codes AND the written-out diagnoses for Axis I & II: **Target Populations (all eligible):** _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF = _____ Has client likely ever had a GAF of 40 or below? Yes No Or a prior GAF of 50 or below if above 50 now? Yes No



SERVICE AUTHORIZATION REQUEST

Level of Care: A B C D E

Requested Start Date (M/d/yy): ____/____/____

Service	Code	Serv. Unit	# Units per Day, Wk(s), or Mo(s).

- OPC LME Use Only -		
# of units	Start Date	Expired Date

Additional Comments: _____

OPC Care Management FAX: (919) 913-4004 Comments from LME: _____

Signature of Requestor

Date (M/d/yy)

Signature of OPC LME Authorizer

Date