700 Ackerman Place, Suite 580
Columbus, OH 43202
292-4700 or (800) 678-6269
*Fax (614) 292-2667

OSU MHCS BEHAVIORAL HEALTH SERVICES

INITIAL AUTHORIZATION REQUEST

Please be advised that autism services covered by The Ohio State University Health Plan Inc. must be Prior Authorized. Any inquiries regarding this may be directed to a behavioral health case manager at the appropriate number listed above. The following information needs to be collected and faxed to OSU Health Plan prior to or immediately following session one. If unable to fax, the information may be mailed in to OSU Health Plan.

Client Name	Member ID #	Client Relationship to Member: Self______ Wife_______ Husband_______ Son_______ Daughter_______
Date of Birth:	Gender: Male ☐ Female ☐	Client Address:
Clinician's Name and Licensure:		Provider Tax ID:
Clinician's Address, Phone, and Fax Number:		
Date of First Service		Preliminary Axis I DX
Primary Care Physician Name		
CPT Code used- (1 Session) ☐ 90801	Ongoing Sessions ☐ 90806 ☐ 90807	☐ 90847 ☐ 90853 ☐ 90857 ☐ Other, list 908______, ______, ______, ______

Test Results (check if attached)

1. ____________________ ☐ Performed by ____________________ Date ____________________
2. ____________________ ☐ Performed by ____________________ Date ____________________
3. ____________________ ☐ Performed by ____________________ Date ____________________
4. ____________________ ☐ Performed by ____________________ Date ____________________
5. ____________________ ☐ Performed by ____________________ Date ____________________
6. ____________________ ☐ Performed by ____________________ Date ____________________
7. ____________________ ☐ Performed by ____________________ Date ____________________

IBI Home Health Techs will be provided by ____________________.

Recommended Augmentive Treatment

OT yes ☐ no ☐ provided by ____________________
PT yes ☐ no ☐ provided by ____________________
Speech yes ☐ no ☐ provided by ____________________

OSU Health Plan Behavioral Health Treatment Authorization

Initial authorization following precertification will be sent to provider once precert is received.

Treatment Authorization Number: Professional ____________________ Team Aides ____________________
Number of Hours Authorized: Professional ____________________ Team Aides ____________________
Date Span of Authorization: Professional ____________________ Team Aides ____________________

Clinician's Signature ____ Date ______________________________

Team Leader's Signature ____ Date ______________________________

Please attach any other clinical information that will establish rationale for continued certification that has not been addressd above.