SECTION 10
Behavioral Health Forms

The MHD Forms Webpage has various forms used by the MHD Behavioral Health Services program. Access this page to find **all** the MHD forms. This Behavioral Health Services Request for Precertification form can be access from the list of forms, which are in alphabetical order.

- Go to the MO HealthNet Web site, https://dss.mo.gov/mhd/providers/fee-for-service-providers.htm under Provider Forms select MO HealthNet forms, or the direct link: http://manuals.momed.com/forms/Behavioral_Health_Services_Request_%20for_Precertification.pdf

The Behavioral Health Services Request for Precertification form

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

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BEHAVIORAL HEALTH SERVICES REQUEST FOR PRECERTIFICATION

PARTICIPANT NAME (LAST, FIRST, MI)		PROVIDER NAME
PARTICIPANT NUMBER	BILLING PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE (IF REQUIRED)
DATE OF BIRTH	PROVIDER FAX NUMBER	PROVIDER PHONE NUMBER
PROVIDER SIGNATURE		DATE
NUMBER OF HOURS USED ON CURRENT PRECERTIFICATION (IF MULTIPLE CURRENT PRECERTIFICATIONS, PLEASE LIST TYPE)		

1. Service Requested (if requesting Family Therapy please see reminder in instructions)

☐ Testing (ages 0-2) Hours _____ Precertification Start Date _____

☐ Individual Therapy Hours _____ Precertification Start Date _____

☐ Family Therapy* Hours _____ Precertification Start Date _____

☐ Group Therapy Hours _____ Precertification Start Date _____

☐ Family Therapy without patient present Hours _____ Precertification Start Date _____

*If requesting Family Therapy, please list all members of the family, relationship to patient and DCN if available.

Is this request for ☐ PCIT ☐ PMT ☐ TF-CBT or ☐ DBT? If so, have you been appropriately trained/certified? ☐ Yes ☐ No
If age is less than 5, will services provided be developmentally appropriate? ☐ Yes ☐ No

2. Has the patient/guardian agreed to his/her treatment plan? ☐ Yes ☐ No

3. Is the therapy court ordered? ☐ Yes ☐ No

4. Have you communicated with other involved therapist/health care practitioners about treatment? ☐ Yes ☐ No

5. If child is in state custody, have you provided a copy of the treatment plan to the Children's Division case manager or contracted case manager? If yes, date _____ ☐ Yes ☐ No
Case manager name _____ ☐ Child not in state custody

6. Is therapy the result of an EPSDT screen? If yes, date of screen _____

BEHAVIORAL HEALTH DIAGNOSTIC CODE

DIAGNOSTIC CODE (PRIMARY)	DIAGNOSTIC CODE
DIAGNOSTIC CODE	DIAGNOSTIC CODE

IS THERE EVIDENCE OF SUBSTANCE ABUSE?
☐ Yes ☐ No

GENERAL MEDICAL CONDITIONS

DOES THE PATIENT HAVE A CURRENT GENERAL MEDICAL CONDITION THAT IS POTENTIALLY RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE ABOVE DIAGNOSTIC CODE(S)?

☐ Yes ☐ No If yes, list condition: _____

DIAGNOSTIC CODE (PRIMARY)	DIAGNOSTIC CODE
DIAGNOSTIC CODE	DIAGNOSTIC CODE

MO 886-4555 (10-15) *PLEASE SEE INSTRUCTIONS ON REVERSE SIDE OF FORM

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Participant Name - Enter the participant's name as it appears on the MO HealthNet ID card.

Participant Number - Enter the participant's number as it appears on the MO HealthNet ID card.

Date of Birth - Enter the participant's date of birth as it appears on the MO HealthNet ID card.

Provider Name - Enter the provider name.

Billing Provider Identifier - Enter the provider identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.

Provider Fax Number - Enter the fax number of the provider making the request.

Provider Taxonomy Code - Enter the provider taxonomy code (if required).

Provider Phone Number - Enter current phone number of the provider making the request.

Signature/Date - The provider of services must sign the request and indicate the date the form was completed.

Number of Hours Used on Current Precertification - List the number of hours used on current precertification. If there is more than one current certification, list the therapy type along with the number of hours used.

QUESTIONS 1 THROUGH 6 MUST BE COMPLETED FOR THERAPIES REQUESTED.

***REMINDER:** When requesting family therapy, please list all members of the family. Only one (1) precertification will be approved and open at a time for family therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN MUST be used for precertification and billing purposes. **PROVIDERS SHOULD NOT REQUEST MORE THAN ONE (1) FAMILY THERAPY PRECERTIFICATION PER FAMILY.** Each child may not be seen separately with parents and billed as family therapy.

Precertification Start Date - Please indicate the date you would like for your precertification to begin. NOTE: The authorized start is the date of receipt or noted subsequent date.

If therapy is the result of a court order a copy should be kept in the patient's file.

DIAGNOSTIC CODES

Enter current version ICD code for behavioral health diagnosis. List general medical conditions diagnostic codes only if applicable.

Precertification requests may be phoned, faxed or mailed into the call center (see below)

Wipro InfoCrossing
P.O. Box 4800
Jefferson City, MO 65102
Phone (toll free): 866-771-3350
FAX: 573-635-6516

AN APPROVED PRECERTIFICATION APPROVES ONLY THE MEDICAL NECESSITY OF THE SERVICE AND DOES NOT GUARANTEE PAYMENT.

MO 886-4556 (10-15)

Direct link:
http://manuals.momed.com/forms/Request_for_Applied_Behavior_Analysis_PreCertification.pdf

The Request for Applied Behavior Analysis (ABA) Precertification form

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES

REQUEST FOR APPLIED BEHAVIOR ANALYSIS (ABA) PRECERTIFICATION

PARTICIPANT NAME (LAST, FIRST, M.I.)	PARTICIPANT DCN NUMBER	DATE OF BIRTH
BILLING PROVIDER NAME	**BILLING PROVIDER NPI**	**PROVIDER TAXONOMY CODE (IF REQUIRED)**
PERFORMING PROVIDER NAME	**PERFORMING PROVIDER NPI**	**PROVIDER PHONE NUMBER**
PERFORMING PROVIDER SIGNATURE	**DATE**	**PROVIDER FAX NUMBER**

SERVICE TYPE REQUESTED

☐ Assessment for Intervention Planning	Total Hours: 0.00	Precertification Start Date:
☐ ABA Intervention	Total Hours (6 months): 0.00	Precertification Start Date:
☐ Continued ABA Intervention	Total Hours (6 months): 0.00	Precertification Start Date:

List relevant behavioral health diagnostic code(s):

USE WORKSHEET BELOW TO DETERMINE TOTAL HOURS REQUESTED. FOR ASSESSMENT, ENTER TOTAL HOURS REQUESTED TO COMPLETE ASSESSMENT. FOR INTERVENTION, ENTER TOTAL HOURS REQUESTED FOR SIX MONTH PERIOD.

Assessment for Intervention Planning

Code	Description	Units Requested	Unit Size	Number of Hours
0359T	Behavior identification assessment		Untimed (typically 60 min)	
0360T / 0361T	Observational behavioral follow-up assessment		30 min	
0362T / 0363T *	Exposure behavioral follow-up assessment		30 min	
* If requesting exposure codes, please attach clinical justification.				Total Hours: 0.00

Intervention

Code	Description	Units Requested	Unit Size	Number of Hours
0364T / 0365T	Adaptive behavior treatment by protocol		30 min	
0368T / 0369T	Adaptive behavior treatment with protocol modification		30 min	
0370T	Family adaptive behavior treatment guidance		Untimed (typically 60 min)	
0372T	Adaptive behavior treatment social skills group		Untimed (typically 90 min)	
0373T / 0374T *	Exposure adaptive behavior treatment with protocol modification		First unit that day = 60 min; each additional that day = 30 min	
* If requesting exposure codes, please attach clinical justification.				Total Hours: 0.00

Continued ABA Intervention

Code	Description	Units Requested	Unit Size	Number of Hours
0364T / 0365T	Adaptive behavior treatment by protocol		30 min	
0368T / 0369T	Adaptive behavior treatment with protocol modification		30 min	
0370T	Family adaptive behavior treatment guidance		Untimed (typically 60 min)	
0372T	Adaptive behavior treatment social skills group		Untimed (typically 90 min)	
0373T / 0374T *	Exposure adaptive behavior treatment with protocol modification		First unit that day = 60 min; each additional that day = 30 min	
* If requesting exposure codes, please attach clinical justification.				Total Hours: 0.00

MO 886-4579 (9-17)

INSTRUCTIONS FOR COMPLETION

HEADER INFORMATION

Participant Name – Enter the participant's name as it appears on the MO HealthNet ID card.

Participant DCN Number – Enter the participant's DCN number as it appears on the MO HealthNet ID card.

Date of Birth – Enter the participant's date of birth as it appears on the MO HealthNet ID card.

Billing Provider Name – Enter the billing provider name.

Billing Provider NPI – Enter the provider identifier (NPI) that will be used for billing services to MO HealthNet. If this is a clinic/group setting the clinic number should be entered here.

Provider Taxonomy Code – Enter the provider taxonomy code (if required).

Performing Provider Name – Enter the performing provider name.

Provider Phone Number – Enter current phone number of the provider making the request.

Provider Fax Number – Enter the fax number of the provider making the request.

Performing Provider Signature/Date – The provider of services must sign the request and indicate the date the form was completed.

Performing Provider NPI – Enter the provider identifier (NPI) for the performing/rendering provider.

Service Requested – Select the service requested, enter total number of hours requested to complete assessment or total intervention hours for six month period.

Precertification Start Date – Please indicate the date you would like for your precertification to begin. NOTE: The authorized start is the date of receipt or noted subsequent date.

Diagnostic Code – List relevant behavioral health diagnostic code(s) per the current edition of the International Classification of Diseases (ICD).

WORKSHEET TO DETERMINE TOTAL HOURS REQUESTED

Complete the worksheet to determine total hours requested (for assessment) or total hours requested for a 6 month precertification period (for intervention):

- Enter the number of units for each procedure code in the Units Requested column
- Use number of units requested and Unit Size to calculate the Number of Hours requested per procedure code
- Enter the number of hours requested in the Number of Hours column
- Add up the Number of Hours column to find the Total Hours for each type of service requested
- Enter the total hours per service type in the Service Requested section

REQUIRED DOCUMENTATION

Documentation required varies by service type and must be submitted with the Request for Applied Behavior Analysis (ABA) Precertification form. Required documentation for each service type is listed below:

SERVICE TYPE REQUESTED:	REQUIRED DOCUMENTATION:
ABA Assessment for Intervention Planning	Diagnostic Evaluation
ABA Intervention (initial)	Assessment for Intervention Planning, Intervention Plan
ABA Intervention (continued)	Current Intervention Plan, Progress Data/Graphs

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Fax 573-635-6516

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MO 886-4579 (9-17)