Behavioral Health Services Prior Authorization Request Form
Attn: Behavioral Health
Phone Number: 419-887-2520 Option 3
Fax: 567-661-0841

PARAMOUNT
ELITE | COMMERCIAL/HMO

Date of Request: _____

Service is:_____Routine___ Expedited/Urgent: explain _____

___ Initial Request ___Concurrent/Continued Stay Request _____Discharge (Last date of service_____)

Member Information

Member Name:_____ DOB: _____

Paramount ID:_____ Member Plan/Group: _____

Secondary Paramount ID#: _____
(if applicable)

Provider Information

Group/Facility Name/Service Location: _____

Billing Provider NPI and/or Paramount ID: _____

Rendering Provider Name and NPI/Paramount ID: _____

Contact Person:_____ Contact Phone and Fax:_____

Provider Status:____Participating Provider ___Non-Participating Provider ____In Contracting Process

Service Information

Service Description	Billing Code	# Units	Dates of Service

ICD-10 Diagnosis Codes: _____

Instructions for Mental Health and Substance Use Disorder Service Requests

- NOT FOR INPATIENT HOSPITAL USE.
- Include admission date and referral source as well as reason for admission.
- Provide pertinent medical and behavioral health history, including risk of SI/HI and Social Determinants of Health.
- Attach clinical documentation showing that member meets medical necessity or other criteria for requested service. (diagnostic assessment summary, treatment plans, clinical summaries). Paramount may require specific documentation for service requested. See https://www.paramounthealthcare.com/providers/medical-policies/policy-library
- Continued Stay Requests must include information relating to any newly identified problems, update on treatment plan goals, how lack of progress towards goals is being addressed, transition of care plan, and any specialized documentation.
- Whether approved or denied, discharge summaries with Last Date of Service are required as soon as possible post discharge.