BH CASE MANAGEMENT AUTHORIZATION REQUEST

For Continued Stay, Supported Employment and Peer Support

FAX TO: 1-888-481-9739

949 Kamokila Boulevard, 3rd Floor, Suite 350
Kapolei, HI 96707

Check one of the Following		
☐ BH CM (continuation)	☐ Supported Employment	☐ Peer Support

***Required Information –** In order to ensure our members receive quality care, appropriate claims payment and notification of servicing providers, all required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. For an urgent* request, do not fill out this form. Please call **'Ohana Health Plan at 1-866-401-7540**.

Member	
'Ohana Member ID:	Today's Date:
Member Last Name:	Member First Name:
Member Phone Number:	Date of Birth:
Home Address:	Phone Number:
Primary Contact and relationship:	Primary Contact's phone number:

Treating Case Management Provider	
Provider ID:	
Case Management Agency:	
Phone Number:	Fax Number:
Case Manager Name:	Case Manager Phone Number:

Diagnosis		
ICD-10 Diagnosis Code		Description:
ICD-10 Diagnosis Code		Description:
Medical Conditions:		
LOCUS Score:		

Service Requested

Planned Date of Service:

HCPC Code	Description of Service	Visits / Frequency

The following documents are required for all Service Requests:

☐ Behavioral Health Assessment *(within a year)*
☐ Current LOCUS *(within 6 months)*
☐ Individualized Treatment Plan *(within 6 months)*

Additional Requirements: Please complete corresponding checklist for the service requested

Supported Employment

☐ Yes ☐ No Compliant with BH CM Frequency of Contact
☐ Yes ☐ No DVR/VA Recipient
☐ Yes ☐ No Transportation

☐ I-9 Form with copies of required ID / Doc
☐ Resume
☐ Individualized Treatment Plan specific to service requested (Page 2)

Peer Specialist

☐ Yes ☐ No Acuity Level 2, 3 or 4
☐ Yes ☐ No Compliant with BH CM Frequency of Contact
☐ Yes ☐ No Participating in Wellness Recovery Action Planning (WRAP)

☐ Individualized Treatment Plan specific to service requested (Page 2)

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Individualized Treatment Plan

Specific to Service Requested

Member Last Name: _____ Member First Name: _____

☐ Supported Employment ☐ Peer Support

Barriers:	**Possible Resolutions:**

Indicate the short-term goals and interventions relevant to the identified service:

Short-Term Goals	**Start Date**	**Units Requested**	**Short-Term Interventions** *(Targeted to be completed within 3-month time frame)*
1.			
2.			
3.			
4.			
5.			
6.			
Total Units Requested:			

Discharge Plan Summary *(Identify possible resources/referrals for member post discharge)*:
1.
2.
3.

	Printed Name	Signatures	Date
Member:			
Case Manager :			