SCOTT&WHITE HEALTH PLAN
The one Texans trust.

MyPlan PPO
Insurance Company of SCOTT&WHITE
The one Texans trust.

Insurance Company of SCOTT&WHITE
The one Texans trust.

SWHP Mental/Behavioral Health Authorization Request Form

**** When completed, please fax to SWHP HSD at: 1.800.626.3042 or 254.298.3450****

Emergent_____Urgent_____Routine_____Retrospective_____Elective_____

Patient Name _____ DOB ____/___/___

Address: _____

Phone (____) _____ Member Number _____

From: Physician _____ Physician NPI # _____

POC: (Point of Contact) _____

Phone: (____) _____ Fax: (____) _____

Request status: Please circle and/or check only what applies

23hr Observation_____ Initial or Concurrent Inpatient_____ Outpatient _____

Intensive Outpatient_____ Crisis Stabilization_____ Day Treatment Program_____

Residential Treatment_____ Partial Hospitalization Program_____

ICD9Code(s) _____ Diagnosis _____

Axis I_____ Axis II_____ Axis III_____ Axis IV_____ Axis V_____

CPT Code (s) / Procedure (s) _____

***Note: While ICD-9 and CPT Codes are not mandatory (only text of diagnoses and procedures), the actual codes that will be billed assists SWHP in more efficiently processing the requested services for a coverage determination in a timely manner to assist you later in prompt payment of any authorized services.**

To: Physician / Facility _____

Service Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____ Fax (_____) _____

Referral requested by: Physician / Provider _____ Member / Patient _____ Other_____

Appointment Date__/___/___ Number of requested visits _____ over _____ (weeks / months)

Next Appointment Date___/___/____ Number of sessions per date_____

Brief Summary of Current Clinical Status: _____

_____

_____

*** Indication(s) / Justification: * Note (Please Attach any pertinent information to assist SWHP in a timely processing of the request. If requesting out-of-network (OON) services, justification for out-of-network referral, indicating the reason in-network service is not available/appropriate, is required in addition to the clinical indication for the service. Services are subject to coverage, benefit, network, and contract policies exclusions.)**

Date ___/___/_____ ***Authorizations will only be given into future contract years when the Member/Employer Group membership renewal information has been finalized with SWHP and service is imminent.**