



## HIV/AIDS Mental Health Treatment Service Authorization Request

Division of HIV and STD Programs (DHSP) will consider treatment service authorization requests for clients living with HIV/AIDS that are Ryan White eligible, or for those whose medical insurance does not cover mental health treatment. HIV/AIDS Mental Health Treatment Service Authorization Request (SAR) forms must be submitted at a minimum of 30 days **prior** to the expiration of the allowable twelve (12) sessions. Submissions must be sent to the attention of the Contracted Community Services Division via **secure fax** to **(213) 381-8022**.

Submissions must include the following:

- Fax cover sheet indicating agency name, contract number, and service category;
- Letter on agency letterhead requesting the treatment authorization, detailing the necessity of the request. The letter must be signed by the agency's executive director or designee;
- A completed Mental Health Services Treatment Service Authorization Request form;
- A copy of client's current **AND** proposed treatment plans;
- Any additional supporting documentation (e.g. progress notes) that would assist DHSP staff in evaluating the request.

Requests for insured clients:

Ryan White is the payer of last resort, and as such, all health insurance coverage, including Medi-Cal and Medicare, must be utilized **prior** to the Ryan White program covering mental health sessions.

For insured clients, you must **also submit** the following:

- Insurance carrier name, telephone number, and policy number.
- Copy of the insurance policy noting that mental health treatment is not covered and/or detailing the maximum number of sessions allowed.
  - If maximum number of sessions have been exhausted, a treatment extension denial from the insurance carrier **must** be submitted with this request for coverage.

Submissions outside of the above parameters will be returned unprocessed. Previous approval of initial therapy or submission of this form does not guarantee approval of continued treatment.



## HIV/AIDS Mental Health Treatment Service Authorization Request Form

**Requesting:**     Authorization for Underinsured client                       Session Extension

Client date of birth: \_\_\_\_\_ Client ID # \_\_\_\_\_ Agency: \_\_\_\_\_

Date of last HIV Medical Visit: \_\_\_\_\_ Date MH Clinician last spoke with HIV provider: \_\_\_\_\_

Is client adherent HIV medications?    No    Yes    Unsure

Does the client have medical insurance?    No    Yes   If yes, is mental health treatment covered?    No    Yes

**Treatment Sessions Requested:** Requested start date: \_\_\_\_\_ Proposed Discharge date: \_\_\_\_\_

Number of sessions requested: Individual \_\_\_\_\_ Family \_\_\_\_\_ Group \_\_\_\_\_

Frequency:     Weekly     Biweekly     Monthly

Previous request approved for client?    No    Yes   (If yes, date(s): \_\_\_\_\_)

DSM Diagnosis: \_\_\_\_\_ Client's current presenting mental health issue:

### Treatment History:

**N/A**  - Requesting authorization for insured client not previously authorized. **Stop here.**

Date treatment began: \_\_\_\_\_ Last Session Date: \_\_\_\_\_

Number of sessions to date: Individual \_\_\_\_\_ Family \_\_\_\_\_ Group \_\_\_\_\_

Has the patient been referred for psychotropic medication evaluation?    No    Yes    Not indicated

Is client taking Psychotropic medications?    No    Yes

Is client adherent Psychotropic medications?    No    Yes    Unsure

### Treatment Planning:

Client's progress related to current mental health treatment plan:

Adhering, progressing and improving – needs more treatment

Adhering, not progressing, not improving

Not adhering, not progressing, not improving



1. Why has current treatment plan not addressed client's mental health needs?

2. What on-going behavioral and/or emotional symptoms, directly related to the client's HIV status, are currently being displayed by the client?

3. List changes in the treatment plan or approach for the client to improve their mental health status. Describe how additional sessions will help the client in achieve their treatment plan goals.

Treating Clinician Name \_\_\_\_\_ Signature \_\_\_\_\_

License# \_\_\_\_\_ Phone: \_\_\_\_\_ Email \_\_\_\_\_

Licensed Clinician Name \_\_\_\_\_ Signature \_\_\_\_\_

License# \_\_\_\_\_ Phone: \_\_\_\_\_ Email \_\_\_\_\_

**DHSP Use Only**

\_\_\_\_\_  Denied  Approved (# of Sessions) \_\_\_\_\_  
 DHSP Program Manager Signature      Print Name/Date

\_\_\_\_\_  Denied  Approved (# of Sessions) \_\_\_\_\_  
 DHSP Clinician's Signature      Print Name/Date

**Reason for denial:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_