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Oregon Behavioral Health Support Program CH-013

Post-Acute Intermediate Treatment Services (PAITS) Authorization

Note which set of documentation is required based on the nature of the request

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Oregon Behavioral Health Support Program

Post-Acute Intermediate Treatment Services (PAITS) Authorization

Form CH-013

Please submit this form and supporting documentation via MMIS to request initial 90-day authorizations and 30-day continued stay authorizations.

Please include a copy of the following supporting documentation for initial 90-day authorizations:

- ☐ Mental/Behavioral Health Assessment signed by Qualified Mental Health Professional (QMHP) within one year of service start date for current authorization*
- ☐ Treatment Plan which must address all the BH consumer's service needs dated within one year of the authorization start date*
- ☐ PAITS Referral Cover Sheet
- ☐ Oregon Health Authority (OHA) PAITS Approval Form
- ☐ PAITS Auth Approved Form
- ☐ Current Discharge Plan

Please Include a copy of the following supporting documentation for 30-day continued stay authorization:

- ☐ Updated Mental Health Assessment
- ☐ Updated Treatment Plan
- ☐ Risk Management Plan (for identified risks i.e., suicide, elopement, fall, etc.)
- ☐ Progress Notes (most recent 30 days)
- ☐ Incident Reports (if applicable)
- ☐ Updated Discharge Plan

Individual/Member Information

Last Name: First Name:

Date of Birth: Primary ICD-10 Diagnosis Code:

☐ (Please check) 18 years of age or older ☐ (please check) SPMI Diagnosis confirmed

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This request will be entered in Medicaid Management Information System (MMIS) as a Prior Authorization (PA) under the PAITS assignment code and for H2013 only. T1020 will be entered as a Plan of Care (POC) in MMIS after approval

Enter the consumer's name as it appears in MMIS

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Medicaid ID (prime number): ☐ (please check) Medicaid eligibility confirmed

Request Information

This request is for (select one):

☐ Initial 90-day Authorization ☐ 30-day Continued Stay Request

Date of Admission to Residential Program (MM/DD/YYYY) if applicable:	Referring Provider Name:
Referring Provider MCD Number:	Rendering Provider Name:
Rendering Provider MCD Number:	Rendering Provider Phone Number:
Rendering Provider Email Address:	Rendering Provider Fax Number:

Procedure Code (select all that apply):

☐ T1020 ☐ H2013

Modifiers (select all that apply):

☐ HK ☐ TG

Number of Units Requested (over full duration):

Dates of Service: From (MM/DD/YYYY): To (MM/DD/YYYY):

Is the individual/guardian aware this referral is being submitted on their behalf? ☐ Yes ☐ No

Signatures

By signing below, the provider or staff completing the form have reviewed the above services and recommend them for this member.

Signature Provider/Staff Submitting Form | **Name and Title** | **Date**

Save As Print Clear Form

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Form CH-013: PAITS
Revised March 2022

30 day continued stay referrals are for any services requested after the initial 90 days. A PA submission must occur for every subsequent 30-day period

Maximum 90 days for initial request and 30 days for continued stay requests

A signature is required for the referral to be processed

This question must be answered. If "no" is selected, please provide an explanation

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Once the form is complete, please submit by email, fax, or mail.

Email: ORBHSupport@comagine.org

Fax: 877-575-8309

Mail: 650 NE Holladay St. Suite 1700, Portland, OR 97232