Student Out-of-Area Prior Authorization Form

Mail to: Behavioral Health Services, c/o CDPHP, 500 Patroon Creek Blvd, Albany, NY 12206-1057 or
Fax to: 518-641-3601, Attn: Behavioral Health

For members with in-network coverage only, services from an out-of-network provider must be medically necessary and prior approved. Please note, student out-of-area authorizations will typically require new review each semester to confirm full-time student status and ongoing medical necessity. All fields must be completed and legible or the request cannot be processed. Approval of this form does not guarantee payment of services. Final determination is based on eligibility, authorization rules, and plan limits.

Client Name: _____ Birthdate: _____

College/University Name: _____ Location: _____

Is client a full-time student? ◯ Y ◯ N How many credits is client taking this current semester? _____

Member ID: _____ Date of first visit (or anticipated start date): _____

Provider Name: _____ Agency/Clinic: _____

Provider Address: _____ Provider Phone: _____

Provider NPI: _____ Tax ID: _____

DSM 5 Diagnosis Code(s): _____

Current Symptoms *(check all that apply)*

◯ Disoriented	◯ SI/HI/Self-Injurious Behavior	◯ Sleep Disturbance	◯ Oppositional/Defiant
◯ Memory Impairment	◯ Emotional Dysregulation	◯ Anxious	◯ Decreased Impulse Control
◯ Hallucinations	◯ Depressed Mood	◯ Panic Attacks	◯ Irritability
◯ Paranoid	◯ Expansive Mood	◯ Phobic	◯ Agitation
◯ Delusions	◯ Psychomotor Retardation	◯ Flashbacks	◯ Food Restriction
◯ Disorganized	◯ Anhedonia	◯ Dissociation	◯ Binging/Purging
◯ Ideas of Reference	◯ Isolation/Social Withdrawal	◯ Obsessions/Compulsions	◯ Other _____
◯ Loose Assoc./Flight of Ideas	◯ Grief	◯ Decreased Energy	_____

Current Functional Impairment *(please rate)*: 0 = None, 1 = Mild, 2 = Moderate, 3 = Marked, 4 = Extreme

_____ Ability to concentrate	_____ Eating habits	_____ Relationships
_____ Activities of daily living	_____ Financial situation	_____ School/Employment

Current Substance Use Disorder? ◯ Y ◯ N **Current SUD Txt?** ◯ Y ◯ N **Past SUD Txt?** ◯ Y ◯ N

Have you communicated with the client's Primary Care Physician? ◯ Y ◯ N

Within the last 12 months, was the client hospitalized for a MH or SUD diagnosis? ◯ Y ◯ N

Within the last 12 months, was the client at risk of hospitalization for a MH or SUD diagnosis? ◯ Y ◯ N

Medications: Name/Dosage/Frequency: _____

_____

_____

Prescribing Physician *(if different from above provider)*: _____ **Is compliance noted?** ◯ Y ◯ N

If not prescribing provider, have you spoken with psychiatric prescriber? ◯ Y ◯ N ◯ N/A

Please describe the impact of symptoms on client's ability to function in school, social life, etc.: _____

_____

_____

_____

Treatment Goals: _____

_____

_____

_____

Anticipated frequency of visits: _____ **Target End Date:** _____

Please note, prior approval is based upon medical necessity of the services, the client being enrolled in full-time coursework, and availability of in-network providers in the client's area. Upon review of this form, a CDPHP Behavioral Health representative will outreach both the member and provider to notify of determination. If applicable, approval will typically cover current semester and prior authorization will be required for any subsequent semester(s). Please contact the CDPHP Behavioral Health Access Center with questions at 1-888-320-9584.