



Health Share Treatment Authorization Request for Higher Levels of Care (HSTAR_HLOC) Form

Instructions for Completing the HSTAR HLOC

General Information

This form is for use by contracted and non-contracted providers who deliver **Partial Hospitalization, Intensive Outpatient, Dialectical Behavioral Therapy (fidelity) or Eating Disorder Intensive Outpatient services** who have a Single Case Agreement (SCA) with Health Share of Oregon.

It is also for use by providers who are making referrals for a current client to access PHP/IOP/DBT or Eating Disorder IOP services.

All mental health assessments and on-going treatment services for these service types must be pre-authorized.

NOTE: Insurance eligibility may change from month to month; Providers are to verify client enrollment prior to each session and before submitting a HSTAR.

Submitting a Valid Request

This form may be submitted via faxed or secure email with required clinical documentation, which includes a current mental health assessment and treatment plan, to the Health Share Behavioral Health Plan Partner (BHPP) assigned to the member. All sections of the form must be filled in completely, including:

- Member identification information including Medicaid/OHP #, or other 3rd party insurance policy #
- Provider information
- ICD-10 diagnosis for an OHP covered condition
- Type of authorization requested (please check appropriate box)
- Requested authorization start date
- Total number of days for requested mental health services

The request is not considered a valid request if the form is not complete, or if clinical documentation is missing. Providers will be notified of an incomplete request.

Providers will receive notification of authorization approval, denial, or the need for additional clinical material within **14 calendar days** of receipt of a complete HSTAR.

To request Prior Authorization

Submit to the appropriate BHPP:

1. A completed HSTAR Form (Section A for an Assessment Request, Section B for an on-going Treatment request).
2. A mental health assessment completed within 60 days of this request (if for ongoing treatment request).
3. The treatment plan (with measureable treatment goals) (if for ongoing treatment request).

4. Information that explains the preauthorization request for on-going treatment services, including additional time or sessions requested (if for ongoing treatment request).

Requests for extensions of authorizations or for additional sessions within a currently active authorization need to be submitted either prior to the end date of the authorization or before the authorized sessions are fully utilized. BHPPs cannot guarantee payment for services provided without active authorization.

Reimbursement and Claims Submission

Health Share of Oregon will pay contracted providers according to the contract terms agreed upon between provider and Health Share. When Health Share is the primary payor, providers must submit detailed claims using the CMS 1500 claim form to PH Tech within 90 days from the date services were delivered.

When the member is covered by other insurance, Health Share is not the primary payor. Providers must submit detailed claims using the CMS 1500 claim form and the primary payor EOB to PH Tech within 12 months from the date services were delivered. Claims submitted outside of these time frames may be denied. Provider shall submit claims to:

Health Share

PO Box 5490

Salem, OR 97304

Attn: Health Share of Oregon Mental Health Claims Processing

For members with dual eligibility, provider must bill and follow the rules of primary insurance provider (including any authorization requirements) prior to submitting claims for Health Share of Oregon to receive payment that aligns with Health Share's responsibility as secondary payor.

Provider must use due diligence in collecting third party resources to offset the cost of the member's mental health treatment. Provider are required to make all reasonable efforts to collect from payors (specifically government programs, commercial insurance, or other third party payors, private or otherwise), for all eligible and contracted costs associated with the member's care.

Additional Provider Billing Questions may be answered by referencing the Health Share Provider Manual, billing support FAQ documents, or by communicating with the appropriate county's Billing Support team via email.

This document is to be used by providers who have a DMAP number (Oregon Medicaid Enrollment Number) and are currently contracted with Health Share. This form may also be completed by providers not currently contracted with Health Share who the Behavioral Health Plan Partner has already agreed to pursue an SCA with and has asked the provider to complete.

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Member Information		
First Name:	MI:	Last Name:
Date of Birth:	Gender:	
Name of Legal Guardian:	Relationship:	
Languages Spoken:	Contact Phone:	
Street Address:		
City:	State:	Zip:

Insurance Eligibility Information
Medicaid ID:
Member's Health Share Behavioral Health Plan <i>(please select one)</i> : <input type="checkbox"/> Multnomah County Behavioral Health Plan <input type="checkbox"/> Clackamas County Behavioral Health Plan <input type="checkbox"/> Washington County Behavioral Health Plan
<i>To verify member eligibility, please look in CIM or contact Health Share Customer Service at 503-416-8090 or 1-866-519-3845</i>

Other Primary Insurance Information <i>(if applicable)</i>
Check Type of Members Primary Insurance and Complete Plan Information: <input type="checkbox"/> Medicare Primary / Medicaid Secondary (Co-Pay Only) <input type="checkbox"/> Third Party Insurance
Carrier:
Group/Policy Number:
Effective Date:
<input type="checkbox"/> Not Applicable, member does not have other primary insurance

Referent/Requestor Information	
Referring Provider:	Agency/Role:
Phone:	Fax:
Email:	
Requested Provider Information <i>(if different than Referent)</i>	
Agency:	Contact Name:
Phone:	Fax:
Email:	

Authorization Request	
ICD 10 Diagnoses:	
Specialty MH Need <i>(Required for PA FFS)</i> :	
Other Relevant Medical and Mental Health Diagnoses:	
<input type="checkbox"/> This is an Initial Request Complete Part A on page 5	<input type="checkbox"/> This is a Concurrent Request for: <ul style="list-style-type: none"> <input type="checkbox"/> Additional sessions in current authorization period <input type="checkbox"/> Additional authorization period Complete Part B on pages 6-7

Part A: Initial Request

For use prior to start of treatment; for a Mental Health Assessment authorization

Treatment Services Requested:

Requested Start Date:

Projected End Date:

Assessment Visits Requested:

Reason for Request:

Part B: Concurrent Request (PHP / IOP / DBT or Eating Disorder IOP)

For use by current Treatment Provider requesting additional sessions in current treatment period or requesting a new authorization for ongoing treatment

Treatment Services Requested:

Number of Days Requested at this Time:

Requested Start Date:

Projected End Date:

Please indicate service being requested:

- IOP PHP Eating Disorder IOP DBT
 Other:

Describe the clinical reasons for the request:

Part B: Concurrent Request, Continued	
Care Coordination Information	
Primary Care Provider	
Name:	Contact Info:
Has Care been Coordinated with this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why not?	
Other Mental Health or SUD Provider	
Name:	Contact Info:
Has Care been Coordinated with this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why not?	
Other Mental Health of SUD Provider	
Name:	Contact Info:
Has Care been Coordinated with this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why not?	
Dental Provider	
Name:	Contact Info:
Has Care been Coordinated with this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why not?	
Current Medication Prescriber	
Name:	Contact Info:
Has Care been Coordinated with this provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why not?	
Current Medications Prescribed:	

Upon Completion of this form, please submit with appropriate clinical documentation to the assigned BHPP:

- Clackamas County Behavioral Health – via Fax: (503) 742-5355
- Washington County Behavioral Health – via Fax: (503) 846-3522
- Multnomah County Behavioral Health
 - For IOP/PHP/DBT to Multnomah Behavioral Health UR via Secure Email: urteam@multco.us or fax to (503) 988-3137
 - For Eating Disorder IOP – to Multnomah Behavioral Health ASOC via Secure Email: asoc.team@multco.us or fax to (503) 988-9383

For questions regarding the completion of this form, please contact the member’s assigned Behavioral Health Plan Partner:

- Clackamas County: 503-742-5348
- Multnomah County: 503-988-9168
- Washington County: 503-291-1155