Health Share Treatment Authorization Request for PA (HSTAR_PA) Form

Instructions for Completing the HSTAR

General Information

This form is for use by providers contracted with Health Share of Oregon as a:

- **Outpatient Mental Health Fee for Service Level of Care Provider**
  - Additional treatment services that exceed the parameters of the self-authorization created by providers must be pre-authorized
- **Outpatient Fee for Service Mental Health Provider**
  - All mental health assessments and on-going treatment services must be pre-authorized.
- **Non-contracted providers who have a Single Case Agreement (SCA) with Health Share of Oregon**
  - All mental health assessments and on-going treatment services must be pre-authorized.
  - SCA providers must contact the member's Behavioral Health Plan prior to completing this form.

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

NOTE: If you do not know which type of Provider you are contracted as, please review the Covered Services and Compensation Addendum(s) which are included as part of your contract.

This document should be used by providers who:

- Have a DMAP number and are currently contracted with Health Share or;
- Providers not currently contracted with Health Share who been approved for a Single Case Agreement by the Behavioral Health Plan Partner, and have been asked to complete it.

Submitting a Valid Request

This form may be submitted via fax 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 visits 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 the following to the appropriate BHPP:

1. A completed HSTAR Form (Section A for an Assessment Request, Section B (including Care Coordination section) 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 120 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.

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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 *(please select one)*: ☐ Multnomah County Behavioral Health Plan ☐ Clackamas County Behavioral Health Plan ☐ Washington County Behavioral Health Plan
To verify member eligibility, please look in CIM or contact Health Share Customer Service at 503-416-8090 or 1-866-519-3845

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

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

Authorization Request	
ICD 10 Diagnoses:	
Specialty MH Need *(Required for PA FFS):*	
Other Relevant Medical and Mental Health Diagnoses:	
☐ This is an Initial Request ***Complete Part A on page 5***	☐ This is a Concurrent Request for: ☐ Additional sessions in current authorization period ☐ Additional authorization period ***Complete Part B on pages 6-7***

Part A: Initial Request *For use prior to start of treatment*	
Requested Start Date:	Projected End Date:
Assessment Visits Requested:	
Reason for Request:	

Part B: Concurrent Request *For use by current treatment provider requesting additional sessions in current treatment period, or requesting a new authorization for ongoing treatment*	
Current Treatment Episode Information	
Current Authorization Number in CIM:	
Start Date of Current Authorization:	End Date of Current Authorization:
First Date of Service:	Number of Sessions to Date:
Expected End date of Current Treatment Episode:	
Treatment Services Being Requested	
Total Number of Sessions Requested at this Time:	
Frequency to Date:	Frequency Anticipated:
Modality Requested (optional):	
<u>Please indicate the number of sessions you are estimating for the following:</u> Individual Therapy Sessions:	Family Therapy Sessions:
Medication Management Sessions:	
Other Services (please indicate CPT code and number of sessions):	
Please describe the clinical reasons for additional sessions, or a reauthorization, and what progress the member needs to make in order to reach their treatment goals:	

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

Upon Completion of this form, please submit, with appropriate clinical documentation, to member's assigned Behavioral Health Plan Partner:

- Clackamas County Behavioral Health – via Fax: (503)742-5355
- Multnomah County Behavioral Health - via Email: asoc.team@multco.us or via Fax: (503-988-9383)
- Washington County Behavioral Health – via Fax: (503)846-3522

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