|  |
| --- |
| **Member Information** |
| First Name:       | MI:       | Last Name:       |
| Date of Birth:       | Gender:       |
| Language(s) Spoken:       | Contact Phone:       |
| Street Address:       |
| City:       | State:       | Zip:       |
| **Insurance Eligibility Information** |
| Member Medicaid ID:       |
| Member’s Health Share Behavioral Health Plan *(please select one)*:  |
| [ ]   | Clackamas County [ ]  Multnomah County [ ]  Washington County |
| *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** |
| Check to indicate all insurance coverage. Complete Primary Insurance Plan Information when applicable. |
| [ ]   | Medicare [ ]  Other Insurance [ ]  N/A - Member has no insurance other than Medicaid |
| Carrier:       Group/Policy Number:       Effective Date:       |
| **Referent/Requestor Information** |
| Name:       | Agency/Role:       |
| Phone:       | Fax:       |
| Email:       |
| **Provider Requested** *(if different than Referent)* |
| Agency:       | Contact Name:       |
| Phone:       | Fax:       |
| Email:       |
| **Authorization Request** *(Identify only one initial OR one concurrent request type)* |
| **This is an initial request for**[ ]  An assessment authorization[ ]  An initial Treatment authorization (SCA providers with continuity of care only)***Complete Parts A & C*** | **This is a concurrent request for:**[ ]  Reauthorization (a new authorization period) [ ]  Additional sessions in current authorization period[ ]  An initial Treatment authorization (after authorized assessment session)***Complete Parts B & C*** |
| **Part A: Initial Request** *(Request must be submitted prior to the delivery of services.)**Use to request an authorization for an initial assessment, or an initial on-going treatment authorization* |
| Requested Start Date:       | Projected End Date:       |
| Briefly describe the clinical reason for the request (do not duplicate the clinical documentation being submitted):       |
| ICD10 Diagnosis:       |
| **Part B: Concurrent Request** (*Request must be submitted prior to the delivery of services.)**Use to request Reauthorization, or to request additional sessions in a currently authorized treatment period*  |
| **Current Treatment Episode Information** |
| Current Authorization Number:        |
| Effective Date:        | End Date:        |
| First date of service under current authorization:        | Number of sessions to date:       |
| Assigned LOC:       ICD10 Diagnosis:       |  |
| **Treatment Services Being Requested** |
| Requested Start Date:       Projected End date:        |
| Briefly describe the clinical reason(s) for additional sessions, or a reauthorization, and what progress the member needs to make in order to reach their treatment goals:       |

Submit this form, Part C, and required clinical documentation (see instructions) 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 the HSTAR form, please contact the member’s assigned Behavioral Health Plan Partner:

* Clackamas County: 503-742-5348
* Multnomah County: 503-988-5887
* Washington County: 503-291-1155