|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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](mailto: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