



Utilization Management

PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6904, 453-6981 Fax: 453-6995

Service Authorization Request	Community Based Case Management
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All fields are **mandatory**. UM may send back requests that are inaccurate or missing fields. The provider may not add additional fields, categories or otherwise amend this form in any way. Requests for authorization must be submitted to UM within thirty (30) days of the provision of service.

Consumer Information

Name (Last Name, First Name, Middle Initial) :		
Date of Birth:	SSN:	Phone:
Homeless: Yes <input type="checkbox"/> No <input type="checkbox"/>	Veteran: Yes <input type="checkbox"/> No <input type="checkbox"/>	Encumbered: Yes <input type="checkbox"/> No <input type="checkbox"/>

The following are legal encumbrances recognized by AMHD: Conditional Release (CR), Released on Conditions (ROC), Mental Health Court, and Jail Diversion.

Insurance information

Health Plan:	UNITED <input type="checkbox"/>	Ohana <input type="checkbox"/>	Aloha Care <input type="checkbox"/>	Uninsured <input type="checkbox"/>	Kaiser <input type="checkbox"/>	Policy #:
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Diagnostic Information

ICD 10 Code:	ICD 10 Code:
ICD 10 Code:	ICD 10 Code:

A minimum of **one** AMHD eligible ICD-10 code is necessary for authorization.

Case Manager Information

CBCM Agency:	Name of Case Manager:
Case Manager's Phone:	Case Manager's Fax:

Provider Information

Agency:	Submitted by:
Phone:	Date of Submission:
Fax:	

Attestation I attest that the service requested is clinically necessary for the above named consumer. I have reviewed and approved the information in the service authorization request.

QMHP Name: (Please Print)	
License type:	Date Signed:
Signature:	

Authorization Information

Admit Date: _____ Cont. Date: _____ Discharge Date: _____



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Authorization Information Continued

Admission Criteria: (Must Meet one of the following)	
	Has an AMHD eligible diagnosis that indicates a significant impairment in functioning as evidenced by: inability to adhere with treatment/recovery, frequent use of crisis services, significant co-morbidity, involvement with the criminal justice system, troubled significant relationships, and neglect or avoidance on ability to fulfill social or vocational activities.
	Consumer is forensically encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion).

Continuation Criteria: (Must meet one of the following)	
	Intensity of service being delivered continues to meet admission criteria
	Complications arising from initiation of, or change in, medication or other treatment modalities
	Forensically Encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion)
	Consumer is experiencing symptoms of such intensity that admission to a higher level of care would likely occur upon discharge.

Discharge Criteria:					
A consumer on Conditional Release (CR) Released on conditions (ROC), Jail Diversion or Mental Health Court may not be discharged without prior permission of the forensic Coordinator.					
Deceased	Unable to locate	Requires Higher LOC	Hospitalization		
Clinically Ready For Discharge	Refuses Treatment	Incarceration	Moved from State/County		
Linked with CCS	Other Payor	No longer encumbered	Long-term care		
Other Discharge Criteria (please specify):					
Discharge to:					

Consumer Name (Last Name, First Name, Middle Initial) :