

Please fax to Behavioral Health: **503-574-8110** | Questions please call: 503-488-2800 or 855-722-8205

NOTE: This form cannot be used to request ABA or TMS.

Member Information		
Last Name:	First Name:	
Insurance ID #:	DOB:	Phone #:
Address:	Date of Service:	Date Span Requested:
Primary Care Physician (PCP):		
Requesting Provider:		TIN#:
Address:		NPI#:
Servicing Provider:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress	All DMAP Administrative Rules, guidelines, and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan .	
Servicing Clinic/Facility:		TIN#:
Address:		NPI#:
Do you have an active DMAP #: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In Progress	All DMAP Administrative Rules, guidelines, and applications to become an enrolled DMAP provider can be found at www.oregon.gov/OHA/healthplan .	
OUTPATIENT – Participating Providers No Chart Notes Required to be Submitted with Request		SPECIALITY OUTPATIENT – Chart Notes Required to be Submitted with Request
<input type="checkbox"/> Assessment ONLY	<input type="checkbox"/> SUD Assessment & UA ONLY	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Level of Care A (see attachment)	<input type="checkbox"/> SUD – Level 0.5	<input type="checkbox"/> Neuropsych Testing
<input type="checkbox"/> Level of Care B (see attachment)	<input type="checkbox"/> SUD – Level 1	<input type="checkbox"/> Electroconvulsive Therapy (ECT)
<input type="checkbox"/> Level of Care C (see attachment)	<input type="checkbox"/> MAT	<input type="checkbox"/> Intensive In-Home Behavioral Health Treatment (IIBHT)
<input type="checkbox"/> Level of Care D (see attachment)	<input type="checkbox"/> Intensive Community Treatment Service (ICTS)	
ICD-10 Code(s):		CPT Code(s) and Units per CPT Code being requested:
<p><u>Expedite</u>- defined as member's life, health or ability to regain maximum function is in serious jeopardy if determination is not made in the standard timeframe. Request must include supporting documentation to substantiate an expedited review.</p> <p>Explanation Required:</p>		
<p>Non-Contracted Providers will need to request an Out of Network Exception. In the event a provider is unwilling to accept DMAP rates additional documentation supporting the enhanced rate will need to be provided. Please indicate your willingness to accept DMAP rates. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>In-Network Benefits: Request must include supporting documentation to substantiate why services cannot be provided by an in-network provider/facility. <input type="checkbox"/> New Patient <input type="checkbox"/> Established Patient Date last seen _____</p> <p>Explanation Required:</p>		
REQUIRED Contact Information:		
Name:	Phone #:	Fax#:

IMPORTANT NOTICE: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message by error, please notify us immediately and destroy the related message.

Yamhill Community Care (YCCO)
Overview of Outpatient Services Levels of Care

The following is a general overview of the different “levels” of care for the YCCO behavioral health outpatient system. The use of “level” language is a method of communication that allows practitioners and other involved parties to understand the overall acuity of the YCCO members needs and the intensity of the services. While the level of care language is helpful, it is important to remember that each member’s needs are unique and some members may move between levels as their clinical needs change. *Note:* This document is meant to be a quick reference guide and is not meant to replace the more detail Level of Care document.

General Presentation

	Level A	Level B	Level C	Level D
Hospitalization	No recent history	No recent history	History of in past 2 years	Recent
Danger to self or others	No imminent	No imminent	May have episodes	Episodic +/-or Elevating
Crisis Management Needs	Likely None	Minimal to None	Minimal to Moderate	Moderate to Frequent
Structures and supports	Good	Fair to Good	Fair to Limited	Limited to None
Functional Impairment	Slight	Moderate	Serious	Severe
Intensity of Treatment Needed	Low	Low	Moderate	High
Care Coordination Needs	None to Minimal	Minimal	Moderate	Substantial

Typical Service Array (I: Infrequent, V: Varies, C: Common, or N/A)

	Level A	Level B	Level C	Level D
Assessment/Diagnosis	C	C	C	C
Crisis Intervention, as needed	I	I	V	C
Individual Therapy	C	C	C	C
Family Therapy	V	V	V	V
Case Management/Coordination of Care	I	V	C	C
Medication Management	I	I	V	C
Skills Training	I	I	V	C
Intensive Specialty Services (e.g. ACT, EASA, Wraparound, IIBHT)	N/A	N/A	N/A	C
Peer Services	N/A	I	V	C
Dual Diagnosis Services (MH and SUD)	I	V	V	V