HIV/AIDS Mental Health Service Treatment Authorization Request Form

Division of HIV and STD Programs (DHSP) will consider treatment service authorization requests for clients living with HIV/AIDS that are Ryan White eligible, or for those whose medical insurance does not cover mental health treatment. **Requests for authorization must be submitted PRIOR to the requested service start date.** A completed Mental Health Services Treatment Service Authorization Request form must be sent to the attention of the Contracted Community Services Division via **secure fax** to **(213) 381-8022** along with a letter on agency letterhead detailing the necessity of the request. The letter must be signed by the agency's executive director or designee.

Submissions made outside of the above parameters will be returned **unprocessed**. Previous approval of initial therapy or submission of this form does not guarantee approval of treatment sessions.

Ryan White is the payer of last resort, and as such, all health insurance coverage, including Medi–Cal and Medicare, must be utilized **prior** to the Ryan White program covering mental health sessions. For insured clients, you must **also submit** a treatment denial from the insurance carrier noting that mental health treatment requested is not covered and/or detailing the maximum number of sessions have been exhausted.

Request Date: ________________ **Agency:** ________________________________ Client ID # __________________

Treating Clinician Name ____________________________________Signature ____________________________________

License# ____________________________Phone: ______________________Email _________________________

Requesting:

☐ **Authorization for Underinsured client**

Insurance Carrier: ______________________________

Also submit *a treatment denial from the insurance carrier noting that mental health treatment requested is not covered and/or detailing the maximum number of sessions have been exhausted.*

☐ **Session Extension**

Number of sessions requested: ___________

Last date client received services __________

Requested treatment start date: ___________

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Request Date: ________________ **Agency:** _______________________________ Client ID # __________________

Date of last HIV Medical Visit: ______________ Date Mental Health Clinician spoke with HIV provider: ______________

Prescribed HIV medications? ☐ No ☐ Yes Adherent to HIV medications? ☐ No ☐ Yes ☐ Unsure

DSM Diagnosis: ____________________________ **Reason for treatment sessions:**

Submitted by:

Licensed Clinician Name ________________________________Signature __________________________Date_________

DHSP Use Only

______________________________ ______________________________ ______________________________

DHSP Program Manager Signature Print Name Date

☐Denied ☐Approved (# of Sessions) ___________

______________________________ ______________________________ ______________________________

DHSP Clinician's Signature Print Name Date

☐Denied ☐Approved (# of Sessions) ___________

Reason for denial:

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