Comagine Health

Oregon Behavioral Health Support Program

Post-Acute Intermediate Treatment Services (PAITS) Authorization

Form CH-013

Please submit this form and supporting documentation via MMIS to request initial 90-day authorizations and 30-day continued stay authorizations.

Please include a copy of the following supporting documentation for initial 90-day authorizations:

- ☐ Mental/Behavioral Health Assessment signed by Qualified Mental Health Professional (QMHP) within one year of service start date for current authorization*
- ☐ Treatment Plan which must address all the BH consumer's service needs dated within one year of the authorization start date*
- ☐ PAITS Referral Cover Sheet
- ☐ Oregon Health Authority (OHA) PAITS Approval Form
- ☐ PAITS Auth Approved Form
- ☐ Current Discharge Plan

Please Include a copy of the following supporting documentation for 30-day continued stay authorization:

- ☐ Updated Mental Health Assessment
- ☐ Updated Treatment Plan
- ☐ Risk Management Plan (for identified risks i.e., suicide, elopement, fall, etc.)
- ☐ Progress Notes (most recent 30 days)
- ☐ Incident Reports (if applicable)
- ☐ Updated Discharge Plan

Individual/Member Information

Last Name:

First Name:

Date of Birth:

Primary ICD-10 Diagnosis Code:

☐ (Please check) 18 years of age or older

☐ (please check) SPMI Diagnosis confirmed

Medicaid ID (prime number): ☐ (please check) Medicaid eligibility confirmed

Request Information

This request is for (select one):

☐ Initial 90-day Authorization ☐ 30-day Continued Stay Request

Date of Admission to Residential Program (MM/DD/YYYY) if applicable:	Referring Provider Name:
Referring Provider MCD Number:	Rendering Provider Name:
Rendering Provider MCD Number:	Rendering Provider Phone Number:
Rendering Provider Email Address:	Rendering Provider Fax Number:

Procedure Code (select all that apply):

☐ T1020 ☐ H2013

Modifiers (select all that apply):

☐ HK ☐ TG

Number of Units Requested (over full duration):

Dates of Service: From (MM/DD/YYYY): To (MM/DD/YYYY):

Is the individual/guardian aware this referral is being submitted on their behalf? ☐ Yes ☐ No

Signatures

By signing below, the provider or staff completing the form have reviewed the above services and recommend them for this member.

_____	_____	_____
Signature Provider/Staff Submitting Form	**Name and Title**	**Date**

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