

INTRODUCTION

Use this tip when you submit an ambulatory detox request using the Authorization Manager tool. To correctly complete an authorization request, providers are required to include certain information.

REQUIRED INFORMATION FOR AMBULATORY DETOX REQUESTS

THE FOLLOWING INFORMATION IS REQUIRED

- **Request type:** Behavioral Health Service Request
- **Place of service:** 57 – Non-Residential Substance Abuse Treatment Facility
- **Review type:** Initial
- **Add Servicing/Facility Provider:**
 - Add the facility/group provider once with the type, *Servicing Provider*
 - Add the facility/group provider again with the type, *Facility*
- **Diagnosis:** Enter diagnosis code or description
- **Procedure:** H0014

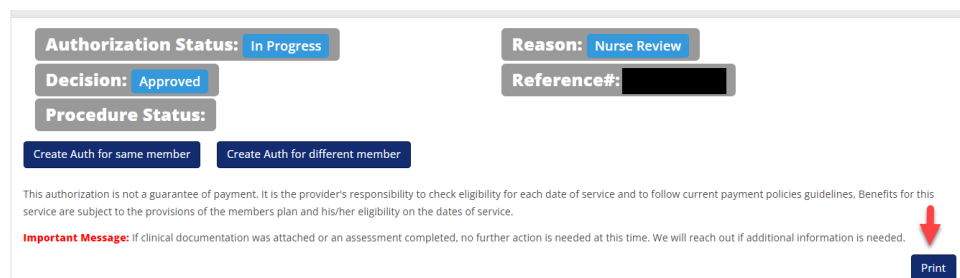
Please note: The CPT code does not need to match the claim if the provider is billing for the same service

After submitting, a new window opens. Populate details as follows:

- **Quantity:** May request a total of up to 22 units for a 22-day span
- **Units:** Units (equal to visits)
- **Frequency:** As prescribed
- **Start date:** Requested start date for service

Click **Submit**. The case will either auto-approve or pend for approval.

- If the case is auto approved, click the **Print** button to open a separate window and view the details of your approval.



Authorization Status: In Progress Reason: Nurse Review

Decision: Approved Reference#: [REDACTED]

Procedure Status:

Create Auth for same member Create Auth for different member

This authorization is not a guarantee of payment. It is the provider's responsibility to check eligibility for each date of service and to follow current payment policies guidelines. Benefits for this service are subject to the provisions of the members plan and his/her eligibility on the dates of service.

Important Message: If clinical documentation was attached or an assessment completed, no further action is needed at this time. We will reach out if additional information is needed.

Print

- If the case pends, you will be asked to upload clinical information.

Please upload additional documentation supporting your request

The request needs further clinical review. Please provide symptoms, lab results with dates and/or justification for initial or ongoing therapy or increase dose and if patient has any contraindications for the health plan/insurer preferred drug. Please provide any additional clinical information or comments pertinent to this request for coverage (e.g. formulary tier exceptions)or required under state and federal laws. See below to upload documentation and add supporting notes related to the request.

Uploaded Documents		Add Documents
ACTION	DOCUMENT NAME	

Notes		Add Notes
ACTION	NOTE TEXT	

[Submit](#)

Notes

- Extension requests must be faxed in. If there has been a break in service, a new case is required.
- If you are signed in as the servicing provider who will bill for the service, save time by selecting “Yes” for the question below. You will be required to enter the provider only once, with the type being facility.

Requesting Provider Same as
Servicing Provider

YES NO

RELATED RESOURCES

[Ambulatory Detox Demo Video](#)

[Accessing authorizations & printing correspondence](#)

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