COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
Service Request Form

1.Today's Date:		2. Service Request Start Date:
Part A	**PART A – MUST BE COMPLETED FOR ALL LEVELS OF CARE**	
PATIENT INFORMATION		
3. Name: (Last, First, Middle)	4. Date of Birth: (MM/DD/YY)	5. Medi-Cal or MHLA Number:
6. Address:		
7. Phone Number:	Okay to Leave a Message? ☐ Yes ☐ No	8. Gender:
9. Perinatal Patient: ☐ Yes ☐ No If yes, provide verification	10. Criminal Justice Involved Patient: ☐ Yes ☐ No If yes, provide Criminal Justice Identification Number: _____	11. Race/Ethnicity (Optional):
PROVIDER INFORMATION		
12. Provider Agency Name:		
13. Address:		
14. Name of Contact Person:	15. Email Address of Contact Person:	
16. Phone Number of Contact Person:	17. Fax Number:	
ELIGIBILITY REQUIREMENTS FOR SPECIALTY SUBSTANCE USE DISORDER SERVICES IN LOS ANGELES COUNTY		
18. Is the patient a resident of Los Angeles County? ☐ Yes ☐ No 19. Is the patient Medi-Cal Eligible? ☐ Yes ☐ No. If yes, please go to question 20. If no, please go to question 21. 20 Are the beneficiary's Medi-Cal benefits assigned to Los Angeles County? ☐ Yes ☐ No. 21. Is the patient a participant in the My Health LA (MHLA) program or other qualified county funded benefits? (e.g. AB 109) ☐ Yes ☐ No		
MEDICAL NECESSITY FOR ALL LEVELS OF CARE		
22. DSM-5 Diagnosis for Substance Use Disorder or Substance Use Diagnosis At Risk For:		
23. Level of Care Determination:		
24. Explanation of Need for Ongoing Services and Justification for Level of Care, as applicable:		
25. Printed Name of Licensed LPHA from the ASAM Assessment Form:		

26. Discipline:	27. Licensed LPHA License Number:

Part B	**PREAUTHORIZATION / AUTHORIZATION SERVICE REQUEST** COMPLETE THIS SECTION **ONLY** IF REQUESTING ONE OF THE SERVICES LISTED BELOW

28. Check One: ☐Preauthorization ☐Authorization ☐*Expedited Authorization ☐Reauthorization (Current Authorization #: _____)

29. Check if the patient is: ☐Youth (under age 18) ☐Young Adult (age 18-20) ☐Adult (age 21 and over)

Preauthorized Services	**Authorized Services**
Residential Services ☐ ASAM level 3.1 Clinically Managed Low-Intensity ☐ ASAM level 3.3 Clinically Managed High Intensity (Population Specific) ☐ ASAM level 3.5 Clinically Managed High-Intensity (Non-Population Specific) ☐ ASAM level 3.7 Medically Monitored Intensive Inpatient Treatment Services ☐ ASAM 4.0 Medically Managed Intensive Inpatient Treatment Services	Withdrawal Management (WM) for Youth Under Age 18 ☐ ASAM level 1-WM (outpatient/ambulatory) ☐ ASAM level 3.2-WM (residential) ☐ ASAM level 3.7-WM (inpatient) ☐ ASAM level 4-WM (inpatient) Medication-Assisted Treatment for Youth Under Age 18 ☐ Medication-Assisted Treatment for Youth Under Age 18 Recovery Bridge Housing - *must submit authorization request via RBH Authorization Request Form*)

30. Name of Provider submitting request:	31. Provider Signature:	32. Date:

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

☐ Approved ☐ Denied ☐ Further review required

Comments:

Reviewed by: Supervisor Reviewer Date:

INTERNAL SAPC USE ONLY This section is reserved for internal SAPC use only.

☐ Approved ☐ Denied ☐ Further review required

Comments:

Reviewed by: Supervisor Reviewer Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to APPLICABLE Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

SERVICE REQUEST FORM INSTRUCTIONS:

1. Enter today's date.
2. Enter requested start date of the service.

PART A

PATIENT INFORMATION

3. Enter the patient name in the order of last name, first name, and middle name.
4. Enter the patient date of birth.
5. Enter patient Medi-Cal number or My Health LA (MHLA) number.
6. Enter patient address.
7. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.
8. Enter the patient gender.
9. Check the box if the patient is a perinatal patient. Please provide verification of perinatal status by submitting documentation or a written statement from qualified individuals, including the physician, physician assistant, certified nurse midwife, nurse practitioner, or other designated medical or clinic personnel with access to the patient medical records. The statement must give the estimated date of confinement or the last date of pregnancy, and provide sufficient information to substantiate perinatal status.
10. Check the box if the patient is a criminal justice (CJ) patient. Must provide documentation from the applicable criminal justice agency (e.g., Superior Court, Probation, Law Enforcement, California Department of Corrections, etc.…) that indicates criminal justice involvement. The Criminal Justice Identification Number refers to any identifying number that indicates that the patient is involved with the criminal justice system (e.g., case number, PB number, etc).
11. Enter the patient race/ethnicity (optional).

PROVIDER AGENCY INFORMATION

12. Enter provider agency name.
13. Enter the address of the provider agency.
14. Enter the name of the contact person at the provider agency.
15. Enter the email of the contact person.
16. Enter the phone number of the contact person.
17. Enter the FAX number at the provider agency.

ELIGIBILITY REQUIREMENTS FOR SPECIALITY SUD SERVICES IN LOS ANGELES COUNTY

Eligibility for the Los Angeles County specialty SUD benefit package must be verified by the SUD provider rendering services to the patient. In order to receive specialty SUD services, a patient must reside in Los Angeles County, and be eligible for Medi-Cal benefits, or a participant in My Health LA (MHLA), or other qualified county funded benefits (e.g. CalWORKs, General Relief, AB 109)

18. Enter if the patient resides in Los Angeles County? Please check yes or no.
19. Enter if the Medi-Cal eligibility has been verified? Please check yes or no. If the Medi-Cal eligibility has been verified, please go to question 20. If the Medi-Cal eligibility has not been verified, please go to question 21.
20. Enter if the Medi-Cal beneficiary's benefits are assigned to Los Angeles County.
21. Enter if the patient is a participant in the My Health LA (MHLA) program or other qualified county funded benefits

MEDICAL NECESSITY DETERMINATION

This section must be completed for all levels of care including outpatient services and opioid treatment programs.

22. Enter the DSM-5 diagnosis or a description of the risk for substance use disorder.
23. Enter the level of care determination.
24. Enter explanation of need for ongoing services and justification for level of care, as applicable.
25. Enter the printed name of the licensed LPHA who signed the full ASAM assessment form.
26. Enter the licensed LPHA discipline.
27. Enter the licensed LPHA license number.

If the patient does not require a preauthorized or authorized service, please skip Part B (questions 27 and 28), and go to straight to questions 29, 30, and 31.

PART B

PREAUTHORIZATION / AUTHORIZATION SERVICE REQUEST

Complete this section only if requesting preauthorized or authorized services.

28. Check the appropriate box for what is being requested: preauthorization, authorization, expedited authorization or reauthorization. For reauthorization, enter the current authorization number. **Expedited Authorization: For cases in which a provider indicates, or SAPC determines, that following the standard timeframe could seriously jeopardize the patient's life or functional status. SAPC will provide notice as expeditiously as the patient's health condition requires, and no later than 3 business days after receipt of the request for service.*
29. Check if the patient is a youth (under age 18), young adult (age 18-20), or adult (age 21 and over)

SIGNATURE AND DATE

30. Enter the name of the provider filling out the form
31. Enter the signature
32. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THE FORM TO:

Fax: (323)-725-2045
Phone: (626)-299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders.htm