



Dialectical Behavioral Therapy (DBT) Authorization

Type of request	<input type="checkbox"/> Initial (To Start Services)	<input type="checkbox"/> Additional		
Member Information				
Name:				
Address:				
ID Number:	Date of Birth:			
Provider Information				
Facility Name:				
Facility Address:				
Facility City / State:	Facility Zip:			
Facility NPI:	Facility TIN:			
Facility Phone Number:	Facility Fax Number:			
Clinical Information				
Date of most recent Functional Assessment (FA):				
Date of most recent Diagnostic Assessment (DA):				
Primary diagnosis:	Secondary diagnosis:			
Service Information				
Service Code	Modifiers	Units	Start Date	End Date
H2019				
H2019				
Exclusionary Services				
If DBT is being provided concurrently with an exclusionary service, complete the rationale section below. Rationale should include a coordinated plan addressing length of time and expected outcome of concurrent exclusionary service provision.				
<ul style="list-style-type: none"> • Partial Hospitalization • Outpatient Psychotherapy • Day Treatment 				
Rationale for concurrent exclusionary service. Describe medical necessity for providing concurrent DBT and partial hospitalization, day treatment, outpatient psychotherapy, psychotherapy group or inpatient hospital.				

Please submit the following with this request:

- Diagnostic Assessment and Functional Assessment
- Treatment plan – individualized treatment plan that contains the following:
 - Treatment goals, treatment objectives and outcomes

Please follow government thresholds and authorization requirements for continued services.

Prior authorization or predetermination confirms medical necessity only and does not guarantee payment. Payment is determined at the time the claim is received and is subject to health plan exclusions and out-of-network benefits. Plan coverage must be in effect for the member at the time services are rendered.

Contact the Provider Contact Center for questions related to claims.