alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

SUD Services DMC-ODS **Authorization Form** OS/IOS/CM/WM

Complete all of the following:

1. CQRT Date: _____ 5. Reporting Unit: _____
2. Client Name: _____ 6. Primary: _____
3. Client InSyst #: _____ 7. Episode Opening Date: _____
4. Provider Name: _____ 8. SUD Program Type: _____

9. **OS/IOS Substance Use Disorder Services request** as indicated on treatment plan (check all that apply):

☐ Individual Counseling	Frequency:	_____	and As Needed	Duration:	_____
☐ Group Counseling	Frequency:	_____	and As Needed	Duration:	_____
☐ Medication Services	Frequency:	_____	and As Needed	Duration:	_____
☐ Family Therapy (LPHAs Only)	Frequency:	_____	and As Needed	Duration:	_____
☐ Collateral Services	Frequency:	_____	and As Needed	Duration:	_____
☐ Patient Education (Grp/Ind)	Frequency:	_____	and As Needed	Duration:	_____
☐ Group Multi-Family Counseling - ADOL	Frequency:	_____	and As Needed	Duration:	_____

Withdrawal Management Services request as indicated on treatment plan (check all that apply)

☐ Observation	Frequency:	_____	and As Needed	Duration:	_____
☐ Medication Services	Frequency:	_____	and As Needed	Duration:	_____

Recovery Support Services request as indicated on treatment plan (check all that apply)

☐ Individual Counseling	Frequency:	_____	and As Needed	Duration:	_____
☐ Group Counseling	Frequency:	_____	and As Needed	Duration:	_____
☐ Recovery Service Monitoring/SAA	Frequency:	_____	and As Needed	Duration:	_____

10. **Case Management Services request** as indicated on treatment plan (check all that apply)

☐ Case Management: Care Coordination	Frequency:	_____	and As Needed	Duration:	_____
☐ Case Management: Service Coordination	Frequency:	_____	and As Needed	Duration:	_____

11. **Medical Necessity** (both required for medical necessity):

☐ Included SUD Diagnosis with individualized written basis (LPHA completing the diagnosis and written basis must meet face-to-face or via telehealth with beneficiary or SUD counselor who completed the assessment. Unlicensed LPHAs must have licensed LPHA co-signature)

☐ ASAM Level of Care (ALOC). May be completed by SUD counselor or LPHA. Differences in LOC and placement must have clinical explanation.

12. Primary Counselor/LPHA: _____ Recommend Approval: ☐ Yes ☐ No
Signature/Credentials

13. Agency Supervisor or Internal CQRT Reviewer: _____ Recommend Approval: ☐ Yes ☐ Pending (30 Day Return) ☐ No
Signature/Credentials

14. CQRT Reviewer **(REQUIRED):** _____ Recommend Approval: ☐ Yes ☐ Pending (30 Day Return) ☐ No
Printed Name

_____ _____
Signature/Credentials (LPHA or Certified SUD Counselor) Date

15. CQRT Chair **(REQUIRED):** ☐ Full Authorization–Start Date: _____ End Date: _____

Returns: ☐ Authorization pending return in 30 Days, by this date: _____

☐ No Authorization for DMC-ODS Services, chart to be returned to CQRT, by this date: _____

CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period).

_____ _____ _____
CQRT Chair Signature (Must be Licensed LPHA) InSyst ID Date

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Use this Addendum if Chart is to be returned

1st Return

Primary Counselor/LPHA Comments:	Supervisor Comments:

Primary LPHA/Counselor: _____ Recommend Approval: ☐ Yes ☐ No
Signature/Credentials

Agency Supervisor: _____ Recommend Approval: ☐ Yes ☐ Pending (30 Day Return) ☐ No

CQRT Reviewer or Chair Comments:

CQRT Reviewer: _____ Recommend Approval: ☐ Yes ☐ Pending (30 Day Return) ☐ No
Signature/Credentials (must be a Licensed, Registered or Waivered LPHA)

CQRT Chair: ☐ Full Authorization–Start Date: _____ End Date: _____
Returns: ☐ Authorization pending return in 30 Days, by this date: _____
☐ No Authorization for SUD DMC-ODS Services – Chart to be returned to CQRT, by this date: _____
CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period).

_____ _____ _____
CQRT Chair Signature/License: InSyst ID Date

2nd Return

Primary Counselor/LPHA Comments:	Supervisor Comments:

Primary LPHA/Counselor _____ Recommend Approval: ☐ Yes ☐ No
Signature/Credentials

Agency Supervisor: _____ Recommend Approval: ☐ Yes ☐ Pending (30 Day Return) ☐ No

CQRT Reviewer or Chair Comments:

CQRT Reviewer: _____ Recommend Approval: ☐ Yes ☐ Pending (30 Day Return) ☐ No
Signature/Credentials (must be a Licensed, Registered or Waivered LPHA)

CQRT Chair: ☐ Full Authorization–Start Date: _____ End Date: _____
Returns: ☐ Authorization pending return in 30 Days, by this date: _____
☐ No Authorization for SUD DMC-ODS Services – Chart to be returned to CQRT, by this date: _____
CQRT Chair Comments: Indicate if any services that have been claimed need to be voided and/or any future services should not be claimed (including time period).

_____ _____ _____
CQRT Chair Signature/License: InSyst ID Date