All Offices:
(919) 651-8401

Online:
AllianceHealthPlan.org

Alliance Health Out of Network Cover Sheet

Date Submitted:

To: Alliance Health/UM Out of Network Authorization Request Coordinator

Client name: Agency name:

Agency Name:

Agency contact person:

Contact person role:

Contact phone number:

Contact email:

Documents attached (Please List):

Additional comments:

Please email all requests and accompanying documents (including cover sheet) to UMoutofnetwork@alliancehealthplan.org

Total Number of Pages (including cover sheet):

-

Helpful Links and Information When Requesting Out of Network Authorizations

This document is to assist providers that are not in our provider network who wish to obtain a single case agreement so that they may provide services to a Medicaid recipient that has Alliance Medicaid. At Alliance we value people having access to the care they need, and to that end, our hope is that this information will help ensure that this process is expedient and efficient.

1. Requests for services require documentation to be submitted as outlined in the Alliance Health Plans. This link references the Alliance Health Medicaid benefit plan, including what documents must be submitted, as well as the Authorization Parameters based on which service is provided.
   https://www.alliancehealthplan.org/providers/authorization-information/#Medicaid_and_Non-Medicaid_Benefit_Plans

2. Alliance Provider Operations Manual. This documents information about Alliance including our purpose, mission, vision, and core values and describes our processes related to participating in the Provider Network including obtaining referrals and authorizations, submitting claims and resolving many issues or problems.
   https://docs.google.com/viewerng/viewer?url=https://www.alliancehealthplan.org/wp-content/uploads/Provider-Operations-Manual.pdf&hl=en_US

3. This link will direct you to the NCDHHS website that has the applicable Clinical Coverage Policies which are the Medicaid guidelines for MH/SUD/IDD services that Alliance Health manages, including entrance criteria and continued stay criteria for the service, trainings required for clinicians providing the service, and more. Alliance Utilization Management will utilize the criteria found in the applicable CCP in determining medical necessity for the requested service.
   https://dma.ncdhhs.gov/providers/clinical-coverage-policies/behavioral-health-clinical-coverage-policies

4. Once a single case agreement is in place, we request that subsequent requests for authorization be submitted electronically, we request that reauthorization requests be submitted electronically through AlphaMCS, which is a secure, web-based system. Utilization Management staff can provide technical assistance for submission of SARS. Providers are set up with log in and instructions for the Alpha system by Alliance's IT department. Prior to being set up with log in, access will not be possible. https://login.alphamcs.com/login

5. In order to maintain HIPPA compliance, please set up a secure login via this link prior to emailing any client information: https://web1.zixmail.net/s/login?b=alliancehealthplan

6. For children/adolescents, please refer to the CALOCUS manual by The American Academy of Child and Adolescent Psychiatry/The American Association of Community Psychiatrists. For adults, please refer to the LOCUS manual by The American Association of Community Psychiatrists.

7. For information on ASAM guidelines, go to this link. https://www.asam.org/

8. Medicaid guidelines do not allow 'backdating' a request, meaning that the start date of the authorization cannot be earlier than the date the Service Authorization Request form is submitted to our Utilization Management department. This does not apply to retrospective authorization requests. A retrospective authorization request can occur when the service has already been provided, and a consumer receives retroactive Medicaid. In such cases, the provider needs to submit all progress notes in addition to all required documentation. In addition, these requests must be submitted within 90 days of the Medicaid eligibility being entered into NC Tracks.**Please note that crisis services (e.g., Inpatient, facility based crisis services) have up to 72 hours from the time of admission to the service for submission of requests.

9. Please submit a separate request for each client. Do not include requests for multiple clients in one document. This will allow for quicker processing.

10. Please ensure that all documents attached do not exceed 3MB in size as this will delay processing.

Alliance Health Out-of-Network Service Authorization Request

Patient's Name:	
Social Security #	DOB:
Current Address:	
City/State/Zip:	
Medicaid #:	County (Medicaid Eligibility):
Attending Provider:	
Legal Guardian: ☐ None ☐ Parent ☐ DSS ☐ Other:	Name:
Diagnosis:	

DATE OF INITIAL ASSESSMENT and/or Subsequent Assessments prior to referral:
☐ MH ☐ SA ☐Voluntary ☐Involuntary
☐Initial Request ☐Reauthorization ☐Discharge ☐** EXPEDITED**

LOCUS	1	2	3	4	5	**Composite Score**	**LOC Recommendation**
I. Risk of Harm	☐	☐	☐	☐	☐		
II. Functional Status	☐	☐	☐	☐	☐		
III. Co-Morbidity	☐	☐	☐	☐	☐		
IV- a. Recovery Environment. (Support)	☐	☐	☐	☐	☐		
IV-b. Recovery Environment. (Stress)	☐	☐	☐	☐	☐		
V. Treatment and Recovery History	☐	☐	☐	☐	☐		
VI. Engagement	☐	☐	☐	☐	☐		

CALOCUS	1	2	3	4	5	**Composite Score**	**LOC Recommendation**
I. Risk of Harm	☐	☐	☐	☐	☐		
II. Functional Status	☐	☐	☐	☐	☐		
III. Co-Morbidity	☐	☐	☐	☐	☐		
IV- a. Recovery Environment. (Support)			☐	☐	☐		
IV-b. Recovery Environment. (Stress)	☐	☐	☐	☐	☐		
V. Resiliency and Treatment History	☐	☐	☐	☐	☐		
VI-a. Acceptance/Engagement (C&Y)	☐	☐	☐	☐	☐		
VI-b. Acceptance/Engagement (Parent/PS)	☐	☐	☐	☐	☐		

Comments:

ASAM Patient Placement Criteria Adult/Adolescent
(See ASAM criteria for placement considerations)

	0	**1**	**2**	**3**	**4**	**5**
I. Withdrawal/Intoxication	☐	☐	☐	☐	☐	☐
II. Medical Complication	☐	☐	☐	☐	☐	☐
III. Behavioral/Emotional Cognitive Complication	☐	☐	☐	☐	☐	☐
IV. Readiness for Change	☐	☐	☐	☐	☐	☐
V. Relapse/Continued use or problem potential	☐	☐	☐	☐	☐	☐
VI. Recovery Environment	☐	☐	☐	☐	☐	☐

Placement Recommendation:

CURRENT(C) and PREVIOUS (P) TREATMENT)

Service	Current / Previous	Comments
Mental Health Outpatient	☐ C ☐ P	
Mental Health Inpatient	☐ C ☐ P	
Substance Abuse Outpatient	☐ C ☐ P	
Detox	☐ C ☐ P	
Substance Abuse Inpatient	☐ C ☐ P	
Other	☐ C ☐ P	

SUBSTANCE USE

Drug of Choice ☐N/A	Age of 1st Use	Route of Usage	Frequency	Amount	Date of Last use
Primary:	Years			Per	
Secondary:	Years			Per	
Tertiary:	Years			Per	
Other:	Years			Per	

MEDICAL: Current Primary Care Physician Name:______________________ Signed Release to Primary Care Physician? ☐Yes ☐ No Medically- ☐ Compliant ☐ Non-compliant ☐Comments:_____						
CURRENT MEDICATIONS	Current Regimen	# of months		CURRENT MEDICATIONS	Current Regimen	# of months
		☐<1 ☐>1				☐<1 ☐>1
		☐<1 ☐>1				☐<1 ☐>1
		☐<1 ☐>1		Other:		☐<1 ☐>1
Allergies: NKA						

Reason for Admission, Continued Stay or other comments:

Request for Service

Service Description & Code		# of Units	Requested	Start Date	End Date	Provider	Site Name or ID	

Clinician Signature:	**Print Clinician Name**	**Date:**

Alliance Health Utilization Management : UMoutofnetwork@alliancehealthplan.org

**Submission does not automatically constitute authorizations. All treatment is subject to medical necessity determination and based on beneficiary eligibility

Contact Name:____ Phone number_________________________ Email____