



All Offices:  
(919) 651-8401



Online:  
[AllianceHealthPlan.org](http://AllianceHealthPlan.org)

## Alliance Health Out of Network Cover Sheet

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

Client name:

Agency name:

Agency contact person:

Contact person role:

Contact phone number:

Contact email:

Hospital Tax ID:

NPI:

Site Address:

Email of where to send contract for review/signature:

Documents attached (Please List):

Additional comments:

Please email all requests and accompanying documents (including cover sheet) to  
[UMoutofnetwork@AllianceHealthPlan.org](mailto:UMoutofnetwork@AllianceHealthPlan.org).

Total 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](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](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: <input type="checkbox"/> None <input type="checkbox"/> Parent <input type="checkbox"/> DSS <input type="checkbox"/> Other:	Name:
Diagnosis:	
<b>DATE OF INITIAL ASSESSMENT</b> and/or Subsequent Assessments prior to referral: <input type="checkbox"/> MH <input type="checkbox"/> SA <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary <input type="checkbox"/> Initial Request <input type="checkbox"/> Reauthorization <input type="checkbox"/> Discharge <input type="checkbox"/> ** EXPEDITED **	

LOCUS	1	2	3	4	5	Composite Score	LOC Recommendation
I. Risk of Harm	<input type="checkbox"/>						
II. Functional Status	<input type="checkbox"/>						
III. Co-Morbidity	<input type="checkbox"/>						
IV- a. Recovery Environment. (Support)	<input type="checkbox"/>						
IV-b. Recovery Environment. (Stress)	<input type="checkbox"/>						
V. Treatment and Recovery History	<input type="checkbox"/>						
VI. Engagement	<input type="checkbox"/>						
CALOCUS	1	2	3	4	5	Composite Score	LOC Recommendation
I. Risk of Harm	<input type="checkbox"/>						
II. Functional Status	<input type="checkbox"/>						
III. Co-Morbidity	<input type="checkbox"/>						
IV- a. Recovery Environment. (Support)	<input type="checkbox"/>						
IV-b. Recovery Environment. (Stress)	<input type="checkbox"/>						
V. Resiliency and Treatment History	<input type="checkbox"/>						
VI-a. Acceptance/Engagement (C&Y)	<input type="checkbox"/>						
VI-b. Acceptance/Engagement (Parent/PS)	<input type="checkbox"/>						
<b>Comments:</b>							

ASAM Patient Placement Criteria Adult/Adolescent (See ASAM criteria for placement considerations)						
	0	1	2	3	4	5
I. Withdrawal/Intoxication	<input type="checkbox"/>					
II. Medical Complication	<input type="checkbox"/>					
III. Behavioral/Emotional Cognitive Complication	<input type="checkbox"/>					
IV. Readiness for Change	<input type="checkbox"/>					
V. Relapse/Continued use or problem potential	<input type="checkbox"/>					
VI. Recovery Environment	<input type="checkbox"/>					
Placement Recommendation:						

CURRENT(C) and PREVIOUS (P) TREATMENT)		
Service	Current / Previous	Comments
Mental Health Outpatient	<input type="checkbox"/> C <input type="checkbox"/> P	
Mental Health Inpatient	<input type="checkbox"/> C <input type="checkbox"/> P	
Substance Abuse Outpatient	<input type="checkbox"/> C <input type="checkbox"/> P	
Detox	<input type="checkbox"/> C <input type="checkbox"/> P	
Substance Abuse Inpatient	<input type="checkbox"/> C <input type="checkbox"/> P	
Other	<input type="checkbox"/> C <input type="checkbox"/> P	

SUBSTANCE USE					
Drug of Choice <input type="checkbox"/> N/A	Age of 1 <sup>st</sup> 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
		<input type="checkbox"/> <1 <input type="checkbox"/> >1			<input type="checkbox"/> <1 <input type="checkbox"/> >1
		<input type="checkbox"/> <1 <input type="checkbox"/> >1			<input type="checkbox"/> <1 <input type="checkbox"/> >1
		<input type="checkbox"/> <1 <input type="checkbox"/> >1	Other:		<input type="checkbox"/> <1 <input type="checkbox"/> >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 \_\_\_\_\_