Montana Department of Health & Human Services
Children's Mental Health Bureau

Integrated Co-Occurring Treatment (ICT) Prior Authorization Request
Form #010 (12/12/16)

Please type or print clearly. All fields must be entered.

Request Submitted By			
It is recommended that a licensed or a supervised in-training mental health professional (ITMHP) complete the authorization request, though it is not required.			
NAME AND TITLE OF PERSON SUBMITTING REQUEST:			
CREDENTIALS: ☐ Dually licensed ☐ LCSW ☐ LCPC ☐ LAC ☐ Licensed Psychologist ☐ MD ☐ Other:			
PROVIDER NAME:			
PHONE NUMBER:	FAX NUMBER:	EMAIL:	
ADDRESS:	CITY:	STATE:	ZIP:

Youth Information			
NAME:	BIRTHDATE:		
SSN:	MEDICAID NUMBER:		
PARENT(S) NAME(S):			
ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:			
CUSTODY: ☐ Parent ☐ Child & Family Services ☐ Juvenile Probation ☐ Dept. of Corrections ☐ Tribal ☐ OTHER: **Complete contact information below for custodian if not parent.**			
CUSTODIAN NAME:			
ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER: FAX NUMBER: EMAIL:			
PARENT/CAREGIVER (CUSTODIAN SIGNATURE ALSO REQUIRED IF MARKED ABOVE) REQUEST FOR ICT SERVICES: I request to participate in ICT services. I have received a document from the ICT provider explaining that ICT services cannot be reimbursed concurrently with several other mental health services and there is a potential for repayment.			
_____ PRINT PARENT/CAREGIVER NAME	_____ PARENT/CAREGIVER SIGNATURE	_____ DATE SIGNED	
_____ PRINT CUSTODIAN NAME	_____ CUSTODIAN SIGNATURE	_____ DATESIGNED	
(Parent/caregiver and Custodian requests may be made on a separate page and submitted. Requests must be signed and dated.)			

Department of Public Health and Human Services ♦ Developmental Services Division ♦ Children's Mental Health Bureau
111 N. Sanders Rm 307 ♦ PO Box 4210 ♦ Helena, MT 59604-4210 ♦ Voice: 406-444-4545

The Following Information Must be Submitted to the Department:	
PRIMARY SED DIAGNOSIS:	
ICD-10 CODE:	DESCRIPTION:
Additional SED diagnoses relevant to treatment (enter N/A if not applicable):	
PRIMARY SUD DIAGNOSIS:	
ICD-10 CODE:	DESCRIPTION:
Additional SUD diagnoses relevant to treatment (enter N/A if not applicable):	

FUNCTIONAL IMPAIRMENT as a result of the Serious Emotional Disturbance indicated by the diagnosis above**.** The youth must consistently and persistently demonstrate behavioral abnormalities in two or more spheres listed below, to a significant degree, well outside normative developmental expectations. The behavioral abnormalities must have been in existence for six months or must be reasonably predicted to last six months and cannot be attributed to intellectual, sensory, or health factors. Please identify the relevant functional impairments, which must be supported by the Biopsychosocial:

☐ (a) failure to establish or maintain developmentally and culturally appropriate relationships with adult care givers or authority figures;

☐ (b) failure to demonstrate or maintain developmentally and culturally appropriate peer relationships;

☐ (c) failure to demonstrate a developmentally appropriate range and expression of emotion or mood;

☐ (d) disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings;

☐ (e) behavior that is seriously detrimental to the youth's growth, development, safety, or welfare, or to the safety or welfare of others; or

☐ (f) behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.

Please attach a current Biopsychosocial assessment which supports referral to the ICT Program

Date of clinical assessment and /or biopsychosocial assessment:
Clinical Assessment
Biopsychosocial Assessment

Current Mental Status (if not included in Biopsychosocial):

Significant incidents related to the behaviors and symptoms of youth's SED and SUD during the last 30 days that justify the youth's need for this level of care. Include dates, frequency, duration and intensity:

Identify services the youth has received related to his/her SED. Include dates the services were provided:

Current medication:

Identify services the youth has received related to his/her SUD. Include dates the services were provided.
Briefly describe the discharge plan and anticipated discharge date:

Initial Treatment Goals:
Plan for family involvement:
NUMBER OF DAYS OF ICT REQUESTED (180 DAYS MAXIMUM): START DATE REQUESTED:

Transmit form to CMHB by fax at 406-444-6864 OR by the State's File Transfer Service at https://transfer.mt.gov/ to CMHB.UR@mt.gov OR mail to address on page 1. DO NOT SEND THROUGH REGULAR E-MAIL AS IT IS NOT SECURE.

NOTE: Processing may be delayed if information submitted is illegible or incomplete.