Supportive supervision re-tiering request form (CBHS)

Washington State Health Care Authority

To successfully fill out this form electronically, first save it to your computer — do not filll this form out in a web browser.

Instructions

Please type or print clearly and fill out form completely. The requester will complete the top portion of this form.

Purpose of form

The supportive supervision re-tiering request form is for requests to change and approved Community Behavioral Health Supports (CBHS) services tier.

If a different tier of CBHS support is being requested, this form can be sent to the payer of the CBHS services for review of this case for potential tier change.

TO:

Medicaid plan assigned

☐ Wellpoint: **CBHSReferralsandAuthorizations@wellpoint.com**

☐ Community Health Plan of Washington: **bhpc@chpw.org**

☐ Coordinated Care: **SupportiveServices@centene.com**

☐ Molina: **cbhsreferrals@molinahealthcare.com**

☐ United Health Care: **mpc_etr@uhc.com**

☐ Fee-for-Service (FFS): **hca1915iservices@hca.wa.gov**

Date of request

FROM:

Provider's name	Email	Telephone

RE:

Client's name (as written in the CARE assessment)	Client's ProviderOne ID	Date of birth (mm/dd/yyyy)
	WA	

HCS:

Client's HCA Case Manager	Email	Telephone

1 Re-tiering request

1. **This section will be completed by the requester. Describe how the client's behavioral needs have changed since the last tiering decision and are not met with the current level of Supportive Supervision AND/ OR Provide a summary of the information that was not considered in the previous tiering decision. Reference the tiering guidance.**

Clarify any increases in behaviors for the client that result in the need for additional 1:1 support. Include information about the behavior, the interventions, and the time needed for these interventions.

2. **List the other Behavioral Support Services the client is receiving:**

- ☐ **Expanded Community Services (ECS)**
- ☐ **Specialized Behavior Supports (SBS)**
- ☐ **RCS Behavioral Health Support Team (BHST)**
- ☐ **Outpatient services with a behavioral health agency**
- ☐ **Other. If selecting 'Other', include a comment clarifying the service the client is accessing. Include the type of service, where the service is being provided, and the service provider's information (name and phone number).**

3. **Include the following documentation along with the Re-Tiering Request form:**

- ☐ **CARE assessment details**
- ☐ **Behavioral Support Plan (ECS/SBS)**
- ☐ **Staffing and behavior logs for the past 30 days**
- ☐ **Other. If selecting 'Other', include a description of the document attached with this request. This includes where the information was obtained and the time frame the information covers.**

Tiering Decision

To Be Completed By the Authorizing Entity (MCO or HCA for FFS).

☐ **Supportive Supervision**

☐ Tier 1 (0.5 - 2 hours a day)
☐ Tier 2 (2.1 - 6 hours a day)
☐ Tier 3 (6.1 - 10 hours a day)
☐ Tier 4 (10.1 - 15 hours a day)
☐ Tier 5 (15.1 - 20 hours a day)
☐ Tier 6 (20.1 – 24 hours a day)

Service authorization from _____ to _____

MCO/HCA response and recommendations::

Signature

To sign this form electronically, do not use the "Fill & Sign" function; instead, simply click in the appropriate signature field to add your signature.

Authorizing signature

Date sent to HCS/AAA and HCA case manager

2 MCO/HCA change notification

This section is used to notify the authorizing MCO or HCA about a Medicaid plan change. When submitting this notification, include the client's newly assigned plan and the effective date of the plan change.

Client changing from:

Medicaid plan assigned

☐ Wellpoint: **CBHSReferralsandAuthorizations@wellpoint.com**
☐ Community Health Plan of Washington: **bhpc@chpw.org**
☐ Coordinated Care: **SupportiveServices@centene.com**
☐ Molina: **cbhsreferrals@molinahealthcare.com**
☐ United Health Care: **mpc_etr@uhc.com**
☐ Fee-for-Service (FFS): **hca1915iservices@hca.wa.gov**

Effective date _____

Client changing to

Medicaid plan assigned

☐ Wellpoint: **CBHSReferralsandAuthorizations@wellpoint.com**
☐ Community Health Plan of Washington: **bhpc@chpw.org**
☐ Coordinated Care: **SupportiveServices@centene.com**
☐ Molina: **cbhsreferrals@molinahealthcare.com**
☐ United Health Care: **mpc_etr@uhc.com**
☐ Fee-for-Service (FFS): **hca1915iservices@hca.wa.gov**

Attach copy of completed Community Behavioral Health Supports (CBHS) Referral Form

How to submit form

Submit the completed re-tiering request form and include supporting documentation (question 3) to the MCO or HCA via secure email with the subject line "CBHS re-tiering request."

Use email addresses on page 1 of this form to submit your request.

The MCO or HCA will confirm receipt of this request within 2 business days.

Once the form is reviewed and processed, the MCO or HCA will return the form and CC the assigned HCS case manager and mcobhoforms@dshs.wa.gov.