



End of Phase 1 Transition Period Information Session for Providers

NJ FamilyCare Behavioral Health Integration

MARCH 2026

Housekeeping



All attendees will enter the meeting on **mute**



This **meeting will be recorded** to act as an ongoing resource



You can **enable closed captions** at the bottom of the screen



Submit your **questions using the "Q&A" function** – direct them to State or specific MCO
(Note: we will aim to respond to all questions directly during or after the meeting. Responses to broadly-applicable questions may be shared publicly)

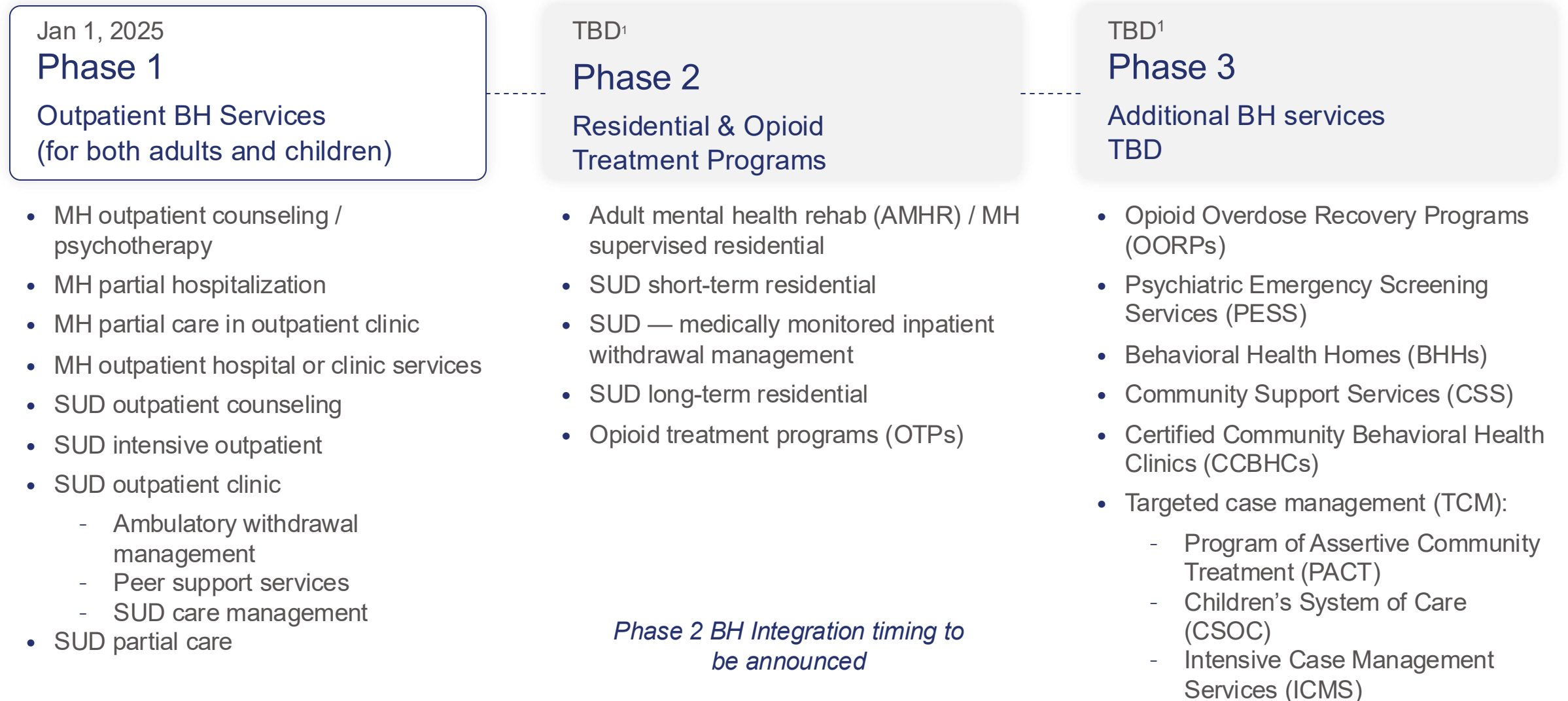


Materials and recording will be published and available on DMAHS website

Agenda

Welcome and housekeeping Shanique McGowan Power, BH Program Manager, DMAHS	10:00–10:05
Context on the transition period and post-transition period policy changes Shanique McGowan Power, BH Program Manager, DMAHS Steve Tunney, Director of Behavioral Health, DMAHS	10:05–10:20
Prior authorization refresher Geraldyn Molinari, Director, Managed Provider Relations, DMAHS Jana Lang, BH Program Manager, DMAHS	10:20-10:45
Summary of resources and next steps Geraldyn Molinari, Director, Managed Provider Relations, DMAHS Shanique McGowan Power, BH Program Manager, DMAHS	10:45–11:00
State Q&A Steve Tunney, Director of Behavioral Health, DMAHS Geraldyn Molinari, Director, Managed Provider Relations, DMAHS Shanique McGowan Power, BH Program Manager, DMAHS	11:00–11:15
MCO Q&A / Breakouts Aetna, Fidelis Care, Horizon NJ Health, UnitedHealthcare, Wellpoint	11:15–11:30

Phase 1 of BH Integration went live January 1, 2025; Integration of BH services into managed care via phased approach



1. Scope and timing of Phase 2 and 3 to be determined after Phase 1 go-live based on additional analysis and stakeholder input

DMAHS previously extended the transition period

DMAHS **instated transition period for Phase 1 services**, during which:

- Providers **must submit PA requests** for all Phase 1 services, which MCOs are required to **automatically approve**
- MCOs will **pay out-of-network providers Medicaid FFS rates** for all claims that are:
 - Submitted with **no errors**
 - Have a **PA on file for PA-required services**

Beginning Nov 1, 2025, DMAHS began a process to end the transition period

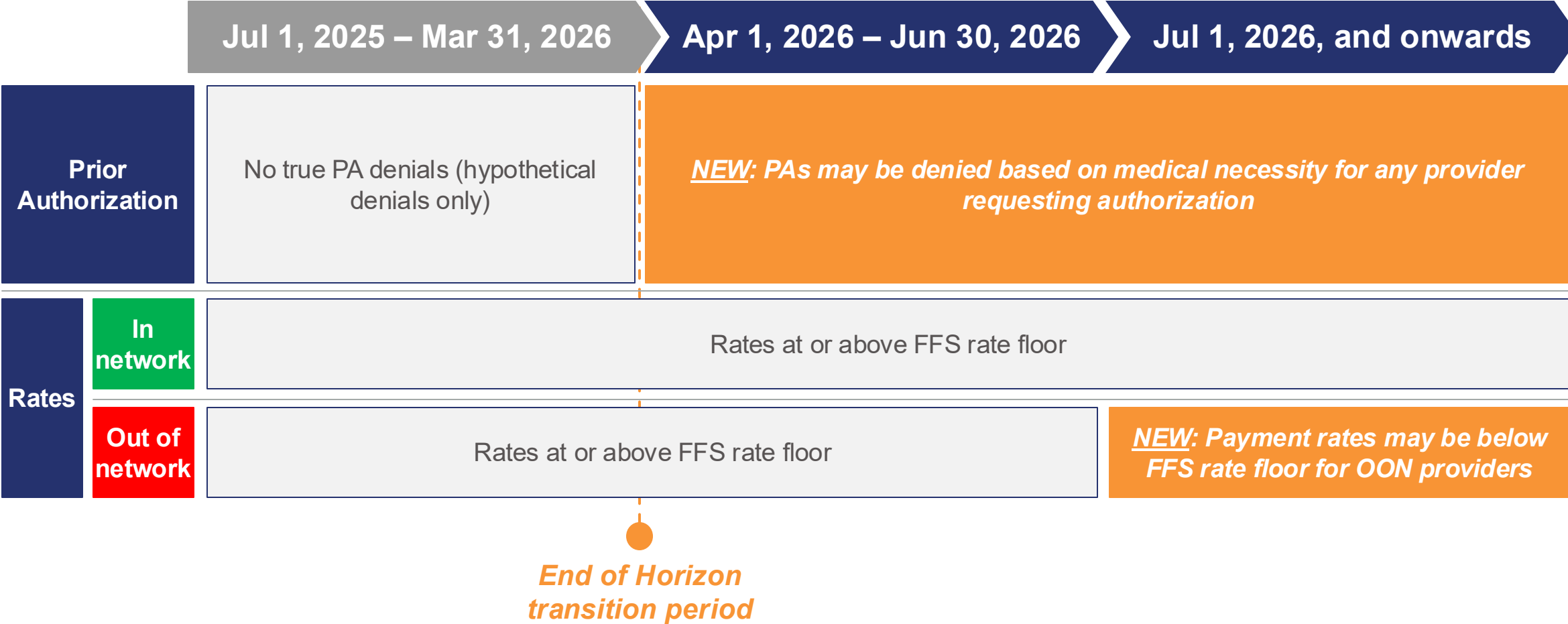
DMAHS began a **process to end Phase 1 transition period for all MCOs** on November 1, 2025

Transition policies will continue to be **lifted on an MCO-by-MCO basis over the coming months**, as each MCO demonstrates readiness to end the transition period

Aetna ended Phase 1 transition period policies on November 1, 2025 and **Horizon will end Phase 1 transition policies April 1, 2026**

All other MCOs will continue transition period policies until further notice

Horizon | After April 1, Horizon may deny PA requests based on medical necessity; after July 1, OON providers may be paid below FFS rate floor



Fidelis, United, and Wellpoint remain in the transition period until further notice

Fidelis Care, UnitedHealthcare, and Wellpoint are required to **continue transition period policies until further notice**

This means that these MCOs will continue to implement the following transition period policies:

- Providers must submit prior authorization (PA) requests
 - However, **PAs must be automatically approved and will not be denied for medical necessity**
 - Claims for **PA-required services will be denied if no PA is on file**
- MCOs will continue to pay out-of-network providers using Medicaid FFS rates; these claims must:
 - Be submitted with **no errors**
 - Have a **PA on file for PA-required services** (*out-of-network PA requirements vary by MCO*)

These MCOs will **end transition period policies at different times** once they successfully complete their **final readiness reviews**

Providers will be given advanced notice from the State and MCO each time an MCO is ending their transition period

Prior Auth | Reference PA resources to prepare for the end of the transition period

In partnership with the MCOs, DMAHS has published comprehensive MH and SUD PA guidance documents for providers

The PA guidance documents **help guide providers through the full managed care PA process**

The following content is covered in the documents:

- Phase 1 **PA service requirements** for in-network and out-of-network providers
- Required **administrative and clinical fields** for MH / SUD Phase 1 PAs, including guidance on how to complete them comprehensively
- Guidance on **how to submit MH PA requests through MCO systems and SUD PA requests through NJSAMS**
- **MCO steps to review** a PA request
- **MCO medical necessity criteria** and **sample approval and denial PAs** for each Phase 1 service
- **Turnaround times** and minimum **initial durations** for Phase 1 services
- Guidance on **how to appeal a PA determination** if the request is denied or approved for a reduction in service

The **MH and SUD PA guidance documents** are posted on the [Provider Resources page](#) of the [BH Integration Stakeholder Information website](#)

In 2025, DMAHS also held **MH and SUD PA trainings** to help providers submit quality PAs that meet MCO expectations

These trainings covered:

- MCO steps to review a submitted PA
- How to complete administrative and clinical PA fields
- MCO medical necessity criteria for each Phase 1 service
- Sample approval and denial PA cases for each Phase 1 service

The **training presentations and recordings** for both trainings can be found on the [Provider Resources page](#) of the [BH Integration website](#)

Prior Auth | Four key steps in managed care prior authorization



Determine when PA is required

- For which services is PA required vs. not required?

Complete and submit PA request

- What are the required fields / information I must submit?
- Where do I submit my PA request?

MCO processes PA request

- How does the MCO review my PA?
- How long will it take to process my PA request? (i.e., turnaround time)
- How long will my PA last, if approved? (i.e., authorization duration)

Dispute and/or appeal PA decision

- My PA got denied. What can I do?
- Who can I contact to help me?

Prior Auth | Phase 1 PA submission requirements for in-network and out-of-network providers by MCO as of March 1, 2026

✓ - PA required for service

Light Blue May apply medical necessity criteria
Dark Blue May not apply medical necessity criteria

	Aetna		Fidelis Care		Horizon NJ Health		UnitedHealthcare		Wellpoint	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network ¹	In-network	Out-of-network	In-network	Out-of-network
MH / SUD partial care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MH partial hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Acute partial hospital	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SUD intensive outpatient	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
SUD ambulatory withdrawal management	✓	✓	✓	✓			✓	✓	✓	✓
MH / SUD outpatient counseling and psychotherapy		✓		✓						

Claims will be denied for providers who do not follow these requirements

1. For Horizon: Out-of-network providers who use the HF and UC modifiers or are a nurse psychiatry, psychiatry, child psychiatry, or neurology specialty type do not need to submit PAs for evaluation and management (E&M) service codes; all other out-of-network providers (e.g., primary care physicians) must submit a PA for these E&M codes

Prior Auth | Required fields for complete MH PA request

Category	Required fields
General information	<ul style="list-style-type: none"> • Non-urgent vs. urgent (& clinical reason for urgency) • Type of request (initial vs. extension, renewal, or amendment)
Patient information	<ul style="list-style-type: none"> • Name, phone #, address, DOB, member ID, Medicaid #, Medicare or 3rd party insurance
Provider information	<ul style="list-style-type: none"> • For both requesting provider/facility and servicing provider or facility: <ul style="list-style-type: none"> - Name, NPI, Specialty, Contact info (incl. fax number) TIN, PAR vs. OON
Services requested	<ul style="list-style-type: none"> • Plan of care • CPT or HCPCS code(s) and units • MH treatment requested with frequency / length, start / end date • Level of care requested • Diagnosis description (ICD) & code • Admission date
Clinical documentation	<ul style="list-style-type: none"> • Brief clinical history • Present clinical status (incl. presenting symptoms, medications) • Risk of harm to self or others • Criteria / level of care utilized in past 12 months • Discharge plan (incl. planned discharge level of care, barriers to discharge, expected discharge date)

DMAHS has established a policy requiring MCOs to standardize these fields as the minimum necessary fields for a complete PA request

MCOs may request additional information or fields but a PA request will be deemed complete for turnaround time tracking as long as these required fields are accurately submitted

Field not required but strongly encouraged by MCOs

Prior Auth | Required fields for complete SUD PA request in NJSAMS

Category	Admission module	DSM-5 module	LOCI-3 module
Patient information	<ul style="list-style-type: none"> Demographic information Household / living situation Education / employment Legal / veteran status Insurance info Admission and level of care details 	<i>No patient information fields</i>	<i>No patient information fields</i>
Provider information	<ul style="list-style-type: none"> Agency name, Medicaid ID, Type 2 NPI Referral source Provider tax ID number 	<ul style="list-style-type: none"> Counselor / Supervisor name and contact information 	<ul style="list-style-type: none"> Counselor / Supervisor name and contact information, incl. fax number Supervisor credentials
Clinical information	<ul style="list-style-type: none"> Current substance use Current treatment and medication Medication history Chronic health conditions and diagnoses Recovery support programs Requested start and end date of service Requested number of units for service 	<ul style="list-style-type: none"> DSM diagnoses Age of first substance use Last date of use Frequency of use Past treatment 	<ul style="list-style-type: none"> Acute Intoxication/Withdrawal Biomedical conditions/complications Emotional, behavioral, or cognitive conditions and complications Readiness to change Relapse, continued use, or continued problem potential Recovery environment Level of care recommended, preliminary discharge plan, clinical justifications

Field not required in NJSAMS but required by MCOs

Prior Auth | Where to submit MH and SUD PA requests

MH PA requests

Preferred method: Submit to each MCO via their provider portal

- Provider enters the required PA information into the platform and attaches any necessary documentation — [MCO portal demos in Appendix](#)
- Once submitted, PA requests are sent directly to MCO, who will review and communicate approval decision via portal, fax, phone, or mail

Other ways to submit a request: All MCOs have a phone submission option and 4 of 5 have a fax¹ submission option

- [Contact information and submission instructions in Appendix](#)

For members with presumptive eligibility and those without an active MCO, MH PA gets submitted to the county [Medical Assistance Customer Centers \(MACC\)](#) offices

SUD PA requests

All SUD PA requests for adult and youth must be submitted to MCOs via **NJSAMS**

- Provider enters the required PA information into NJSAMS
- Provider submits and sends information to MCO electronically in real time
- MCO will receive 3 PDF reports (i.e., admission, LOCI, DSM-5 reports)
- MCO reviews and enters PA information into their PA system
- MCO communicates to provider external to NJSAMS (e.g., via MCO PA portal or call/fax) the authorization decision or if additional information is needed

1. UnitedHealthcare does not have a fax submission option

A PA request goes through 3 different types of review once submitted to the MCO

	Administrative review	Clinical review part 1: Completeness	Clinical review part 2: Medical necessity
What is checked?	<ul style="list-style-type: none"> Completion of administrative info (e.g., member/provider IDs) Verify member eligibility 	<ul style="list-style-type: none"> Completeness of clinical info 	<ul style="list-style-type: none"> Clinical appropriateness and evidence of medical necessity
Who conducts the review?	<ul style="list-style-type: none"> MCO utilization management (UM) staff 	<ul style="list-style-type: none"> Licensed UM staff (LCSW, RN, LCADC, etc.) 	<ul style="list-style-type: none"> Licensed UM staff or UM medical director (MD)
Potential outcomes	<ul style="list-style-type: none"> If member is ineligible: PA is automatically rejected If admin info is incomplete and member is eligible, MCOs may: <ul style="list-style-type: none"> - Administrative denial - Follow up with provider for more information - Proceed to clinical review If admin info is complete and member is eligible: Proceed to clinical review 	<ul style="list-style-type: none"> If clinical information is incomplete: MCO may follow up with provider for more information If clinical information is complete: Proceed to medical necessity review 	<ul style="list-style-type: none"> If medical necessity met: Approval If medical necessity not met: Denial <ul style="list-style-type: none"> - <i>All medical necessity denials must be confirmed by medical director</i>

Beginning April 1, 2026, **Horizon** will join Aetna as the only MCOs who can deny Phase 1 PA requests for medical necessity

Prior Auth | Maximum turnaround time of a PA request for managed care covered services depends on urgency designation

Some services are always urgent, and others depend on admission method or provider / MCO discretion

	Always urgent	Can be urgent <i>if referred from inpatient, residential, or ER screening</i>
MH	<ul style="list-style-type: none"> Acute partial hospital (APH) 	<ul style="list-style-type: none"> Partial hospital (PH) Partial care (PC)
SUD	<ul style="list-style-type: none"> Ambulatory withdrawal management (AWM) Intensive outpatient (IOP) 	<ul style="list-style-type: none"> Partial care (PC)

Any service can additionally be classified as urgent by provider / MCO discretion

Maximum turnaround times

Urgent services:

- **24 hours**
- If PA request is incomplete, MCO must request additional information within 24 hours of PA receipt
 - Clock resets upon MCO receipt of updated PA, with decision to be rendered within **24 hours**
 - TAT time from receipt of original PA within **72 hours**

Non-urgent services:

- **7 calendar days**

Prior Auth | Minimum initial authorization duration

DMAHS has worked with MCOs to set **minimum initial authorization durations** for certain BH services to ensure that members receive care for an appropriate amount of time and to give providers sufficient time to develop and implement a treatment plan

Service	<u>Minimum</u> Initial Authorization Duration ¹
MH Acute Partial Hospital and Partial Hospital	14 days
MH Partial Care	14 days
SUD Partial Care and IOP	30 days
Ambulatory Withdrawal Management (AWM)	5 days

Note: Horizon does not require authorization for AWM

After the initial authorization, MCOs may set different durations at their discretion based on member needs

1. These are required minimums. MCOs can grant longer durations based on member needs at MCO's discretion

Prior Auth | Right to appeal and request continuation of benefits

Step 0: Receive PA decision letter

If an initial or extension authorization is denied, members and providers will receive a letter from MCO

For extensions, MCOs must send notice 10 days before end of service authorization

The letter outlines:

- **MCO decision** to deny or reduce request
- **Steps to appeal** and continue services
- **Representation options**

Step 1: Request continuation of benefits

Members or representatives must request continued benefits:

- On or before the last day of current authorization; or
- Within 10 days of receiving the denial letter.

Example: If the letter arrives 5 days before authorization ends, request continuation within 5 days after receiving it

Step 2: Request Appeal (starting with first level)

Members have **60 days** from the denial date on decision letter to appeal (verbally or in writing).

Members can request appeals on their behalf through providers or authorized representatives

Three levels of appeal

- 1 **Internal Appeal:** Formal internal review by MCO
- 2 **External/IURO Appeal:** External appeal conducted by an Independent Utilization Review Organization (IURO)
- 3 **Medicaid Fair Hearing:** This can take place in parallel with external/IURO appeal or afterwards if decision is not in member's favor

Join MCO networks to prepare for when all MCOs end transition period polices...

We encourage you to credential and contract with all five MCOs



Note: If you are an out-of-network (OON) provider, **requirements may vary by MCO**. You are encouraged to **coordinate with each MCO** to understand specific expectations

...and to ensure member access, FFS rates, and simplified PA processes



Ensure your members have **adequate access and do not experience disruptions** in their care



Guarantee fee-for-service (FFS) reimbursement rate, rather than single case agreement (SCA)-specific rates



Limit prior authorization (PA) submissions **to only BH services that require them**

Summary of guidance and available resources for providers to ensure readiness for MCOs lifting transition period policies

Key next steps for providers for the end of the transition period

- ✓ **Check which MCOs your members are enrolled in** and try to **contract and credential with all MCOs** relevant to your client population
 - If you are **unwilling to contract** or credential with all your members' MCOs before they end their transition period policies, and thus remain **out-of-network**:
 - **Outreach all members** who are enrolled in MCOs that you are not contracted with and refer them to **MCO BH Care Management** to connect them with a care manager
 - Work with MCOs to follow their **authorization / SCA process**
- ✓ Ensure the appropriate staff **know the prior authorization (PA) process** for each MCO and are well-trained on State/MCO guidance
- ✓ **Ensure PAs are active and on file** for all members receiving PA-required services

Available resources

- ☆ [End of Phase 1 Transition Period Provider Guidance](#)
 - [MH PA Guidance document](#)
 - [SUD PA Guidance document](#)
 - [MH PA Guidance and Medical Necessity training](#)
 - [SUD PA Guidance and Medical Necessity training materials](#)
 - [Provider Guidance Packet](#)
 - [MCO-led Integrated Care Management Training materials](#)
 - [DMAHS BH Integration Points of Contact Document](#)

All resources can be found on the [BH Integration Stakeholder Information website](#)

Network | If you have questions about contracting, credentialing, or single case agreements issues, please contact the MCO's network representatives

Payer	Network contact information
Aetna	<ul style="list-style-type: none">• Email: Katelyn.Mignone@Aetna.com• Phone: 1-855-232-3596<ul style="list-style-type: none">- Press * for healthcare provider. Follow prompts for customer service needs.
Fidelis Care	<ul style="list-style-type: none">• Email: wc_njpr@fideliscarenj.com• Phone: 1-908-415-3101
Horizon NJ Health	<ul style="list-style-type: none">• Email: BHMedicaid_@horizonblue.com
UnitedHealthcare	<ul style="list-style-type: none">• Email: njnetworkmanagement@optum.com
Wellpoint	<ul style="list-style-type: none">• Email: provider.relations.NJ@carelon.com• Phone: 1-800-397-1630

Need help? Visit the State's BH Integration Stakeholder website or contact the member's MCO; if you cannot reach a resolution, outreach DMAHS

BH Integration Stakeholder Information website

The [Provider Resources webpage](#) on the [BHI stakeholder website](#) has the following resources:

- [Provider guidance packet](#)
- End of transition period readiness guidance document
- Prior DMAHS training materials and recordings
- Additional resources with information on program processes

Member's Managed Care Organization

For specific member inquiries and MCO-related questions, please contact the member's MCO:



Aetna Fidelis Care Horizon NJ Health



UnitedHealthcare Wellpoint

Refer to key MCO points of contact [here](#) or also in [provider guidance packet](#)

DMAHS – Office of Managed Health Care

If your issue is related to **contracting & credentialing, claims & reimbursement, appeals, or prior authorizations**, then contact **OMHC**:

mahs.provider-inquiries@dhs.nj.gov

- Include specific details regarding your claims
- If multiple claims are impacted, the information should be summarized using an Excel file
- All Protected Health Information (PHI) must be sent securely

DMAHS – Behavioral Health Unit

If your issue is related to **policies & guidelines, access to services, or general questions**, then contact DMAHS BH Unit:

dmahs.behavioralhealth@dhs.nj.gov

1-609-281-8028



State Q&A

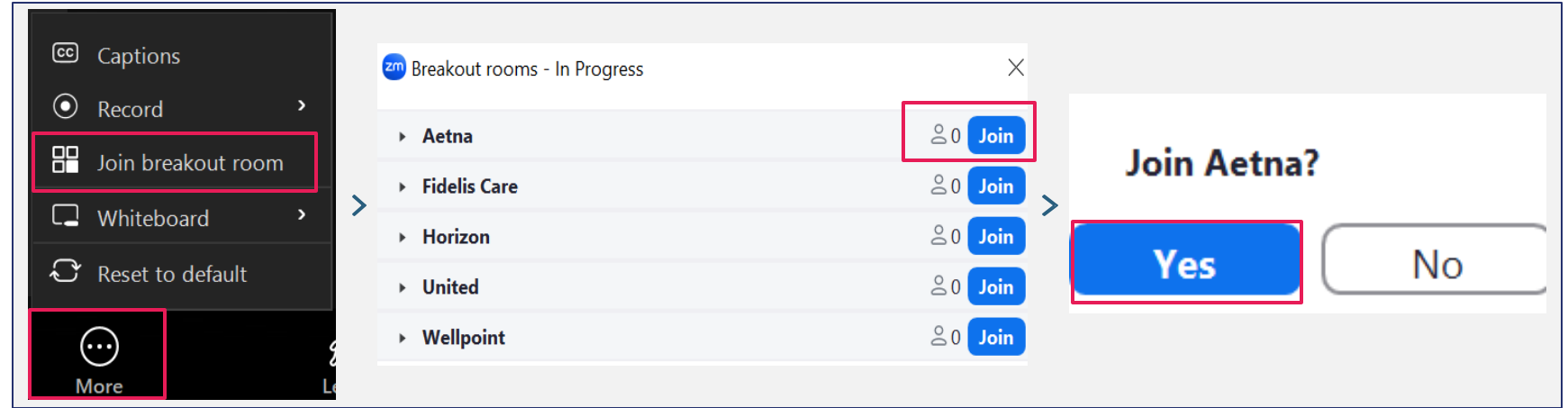
- *The State Room Q&A should focus on general questions about state processes and policies*
- *Please reserve MCO-specific inquiries and concerns for the MCO Q&A in the breakout rooms*



MCO Q&A | Choose your breakout room to direct questions to specific MCOs

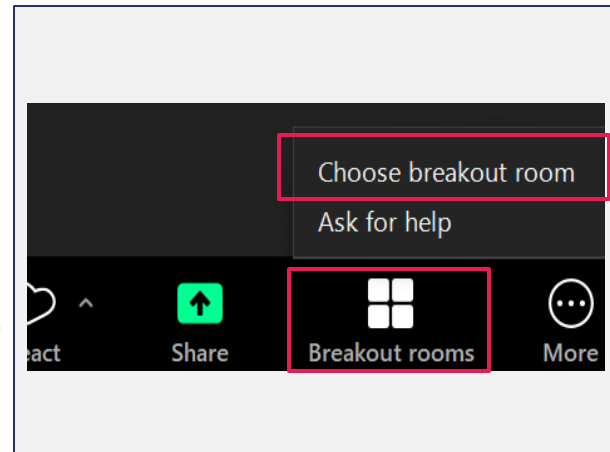
To join a breakout room:

1. Click "**Join breakout room**" on toolbar at the bottom of the Zoom. If the button is not visible, click "More" and then "Join breakout room".
2. Click "**Join**" for the MCO room you wish to be in
3. Click "**Yes**" to be moved into the room



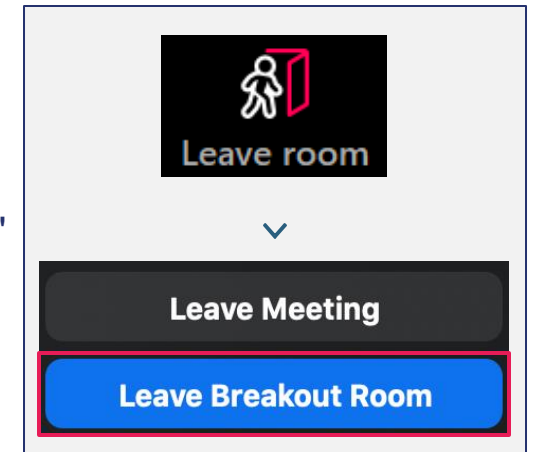
To switch to another MCO room:

1. Click the "**Breakout room**" button on the toolbar at the bottom of the zoom
2. Then, click "**Choose breakout room**"
3. Like above, click "**Join**" for the MCO room you wish to be in



To go back to the Main Room:

1. Click the "**Leave room**" button on the bottom right of the screen
2. Click "**Leave Breakout Room**"



Appendix

Network | Contracting is different than credentialing

Credentialing

The process by which MCOs **verify and assess** the qualifications, experience, and professional background of healthcare providers who wish to join their network

Contracting

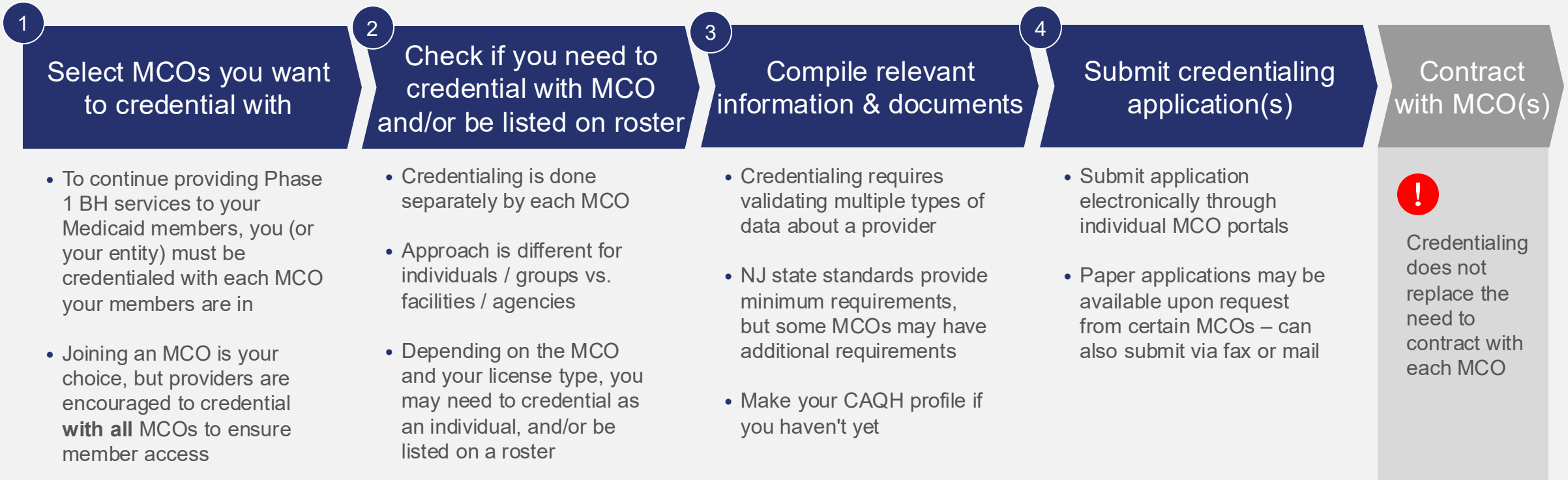
The process of establishing a **formal agreement** between the healthcare provider and the MCO, defining the **terms and conditions** under which the provider will **deliver healthcare services** to the MCO's members

Providers must contract with MCOs in addition to credentialing

- ☆ Horizon requires contracting before credentialing
- ☆ Other MCOs conduct processes simultaneously (Aetna, Fidelis, United¹, and WellPoint)
- ☆ Providers should work with contracting teams at each MCO to confirm and initiate contracting process

1. For United, facilities treated differently, and some require contracting before credentialing

Network | Credentialing process: Four steps to credential



Network | We encourage you to participate with all five MCOs to ensure member access

MCOs are required to contract and credential any willing and qualified provider who can deliver BH Phase 1 services for at least 2 years

You can choose to credential with any of the five NJ FamilyCare MCOs, but participation with all five is recommended, as members may change MCOs over time



Following provider types must credential and contract with all 5 MCOs¹ :

- Psychiatrists
- Advanced Practice Nurses (including Psychiatric Nurses)
- Physician Assistants
- Psychologists (including Neuropsychologists)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family Therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Licensed Clinical Alcohol and Drug Counselors (LCADC)

1. Facilities are credentialed separately to individuals and are not credentialed by specialty

Network | Credentialing is typically different for individuals and group practices vs. facilities / agencies



Individuals / Groups



Licensed Facility / Agency

Who this applies to	<ul style="list-style-type: none"> Independent practitioners and/or multiple providers practicing in a group practice 	<ul style="list-style-type: none"> A licensed healthcare location, such as a hospital, outpatient clinic or home health agency
Credentialing requirements	<ul style="list-style-type: none"> Credential individually using Type 1 NPI 	<ul style="list-style-type: none"> Credential as an entity using Type 2 NPI – at Facility / Agency level
Rostering requirements	<ul style="list-style-type: none"> Groups may be required to list licensed individuals and OBAT navigators on group roster 	<ul style="list-style-type: none"> May be required to list all licensed practitioners and peers on facility / agency roster
Network Directory	<ul style="list-style-type: none"> Listed individually on MCO network directory 	<ul style="list-style-type: none"> Only Facility / Agency listed on MCO network directory. If individuals want or need to be listed, must credential individually

Network | Compile the relevant information and documents

Not exhaustive

A high-level, non-exhaustive summary of information and documentation that must be submitted is below, but providers are encouraged to review the application specific to your provider type and the specific requirements of each MCO

NJ state standards require validation of (at a minimum):

- Licensing:** E.g., valid license to practice, data from licensing board
- Experience:** E.g., relevant degree, completion of residency/post-grad training as applicable
- Liability, sanctions and insurance:** E.g., professional liability claims history, malpractice insurance, past sanctions
- Provider health:** E.g., any physical/mental health condition that affects ability to provide care, history of SUD
- Attestations:** Completeness and correctness of application



Additional MCO requirements for Individual providers

- TIN/NPI
- Servicing location(s)
- Disclosure of ownership
- Special needs/Aged Blind or Disabled (ABD) form indicating experience with specialty populations
- Background check when applicable
- Americans with Disabilities Act (ADA) survey / attestation

Additional MCO requirements for Facility / Agency

- Americans with Disabilities Act (ADA) survey/attestation
- Certificate of facility insurance
- Copies of state license(s) for each service location
- Accreditations from an approved accrediting body
- Facility roster
- Background check when applicable

Network | All providers, except physicians, must submit separate applications to each MCO

Submit application electronically via each MCO portal



[Aetna link](#)



[Fidelis link](#)



[Horizon link](#)



[UHC link](#)



[WellPoint link](#)

Paper applications for each MCO can be requested from the MCO website or MCO credentialing representative

Exception: Physicians

Physicians have the option to submit a single application that can be used across all five MCOs.

[NJ Universal Physician Credentialing Form Link](#)

Note: Physicians can still choose to submit separate applications through each MCO portal

Aetna | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Additional information guidance:

- For continued Stay reviews, please submit the last 30 days of clinical notes if applicable

Where to submit MH PA requests:

Provider portal (preferred method):

- Availability: [Access Availability Here](#)

Call or Fax:

- **Call:** 855.232.3596
 - Follow prompts to BH. Request an authorization with our intake team.
- **Fax:** 844.404.3972
 - Submit with the Prior Authorization Request form on the ABH NJ Website.

How providers will be notified of MH PA decisions:

- Decisions sent back to provider via fax or phone call
- PA decisions will also be available in Availability if provider submitted the original PA via the portal

SUD Prior Authorizations

Additional information guidance:

- Please provide the contact information of the clinician that would need the prior authorization information.
- If able, please include a fax number as this is the most streamline way to communicate.
- For Continued Stay reviews, update all 6 dimensions and provide any necessary information to justify the need for extended treatment. This can include faxing us:
 - Treatment plans, progress notes, etc.

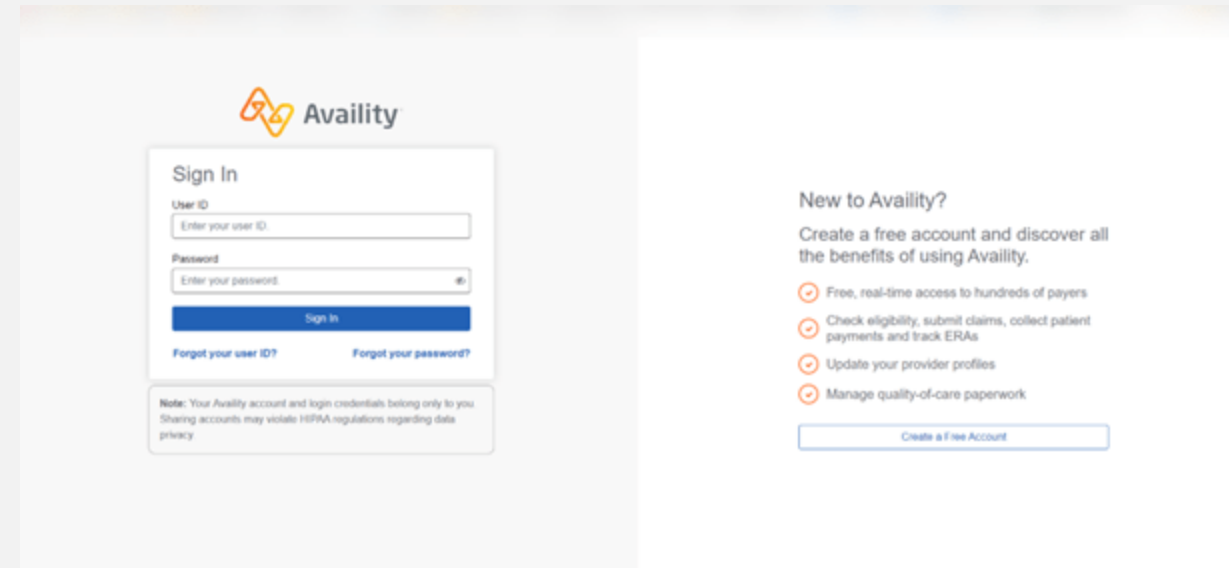
Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- Decisions sent back to provider via fax or phone call

Aetna MH PA requests using our portal

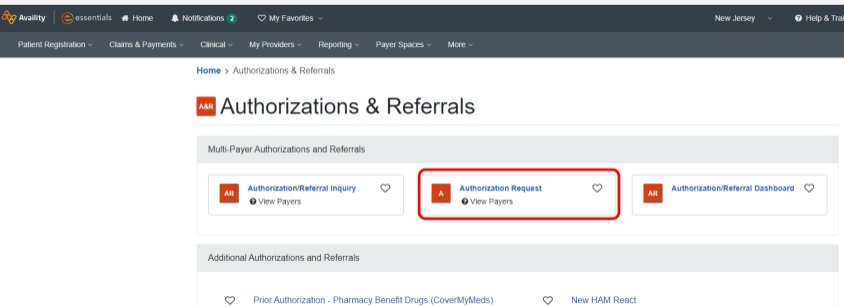


The screenshot shows the Availity portal sign-in interface. At the top center is the Availity logo, which consists of three interlocking orange triangles followed by the word "Availity" in a sans-serif font. Below the logo is a "Sign In" section with two input fields: "User ID" with the placeholder text "Enter your user ID" and "Password" with the placeholder text "Enter your password" and a small eye icon to toggle visibility. A blue "Sign In" button is positioned below the password field. Underneath the button are two links: "Forgot your user ID?" and "Forgot your password?". A small note at the bottom of the sign-in box reads: "Note: Your Availity account and login credentials belong only to you. Sharing accounts may violate HIPAA regulations regarding data privacy." To the right of the sign-in box is a "New to Availity?" section. It contains the text "Create a free account and discover all the benefits of using Availity." followed by a list of four benefits, each preceded by an orange circle with a white checkmark: "Free, real-time access to hundreds of payers", "Check eligibility, submit claims, collect patient payments and track ERAs", "Update your provider profiles", and "Manage quality-of-care paperwork". At the bottom of this section is a blue "Create a Free Account" button.

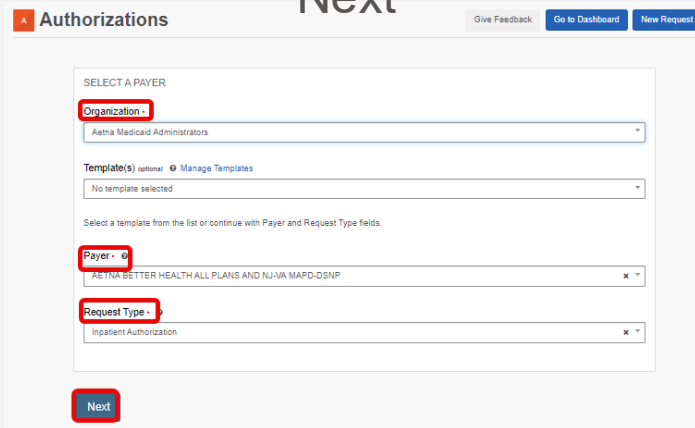
Submit PA using Availity Portal
[Access Availity Here](#)

Submitting Authorizations in Availity

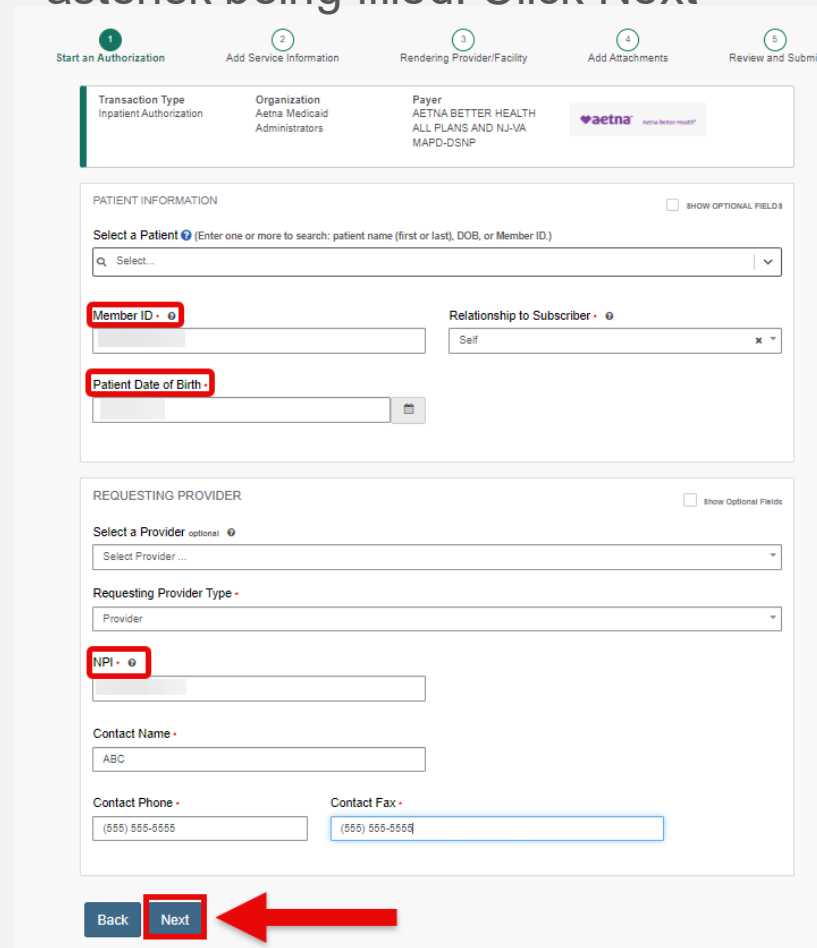
1 Select Authorization Request



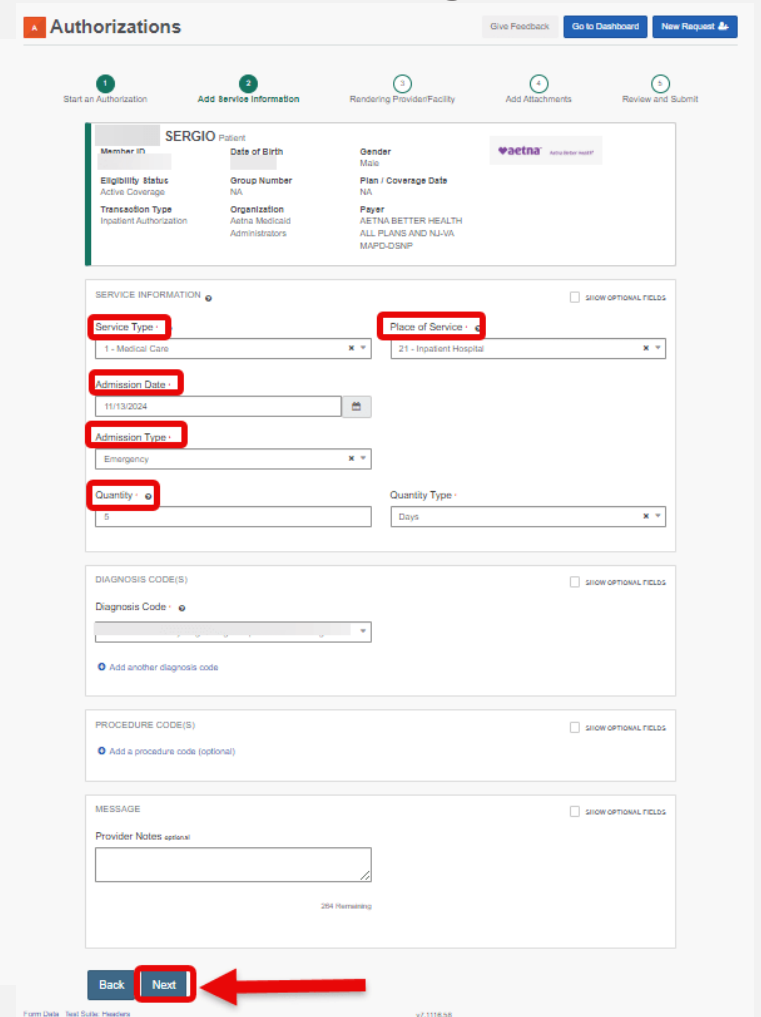
2 Enter applicable info and click Next



3 Enter the information for each asterisk being filled. Click Next



4 Enter the information for the authorization. Click Next



5 Enter the provider info and click Next

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender	
Eligibility Status	Group Number	Plan / Coverage Date	
Transaction Type	Organization	Payer	

Service Provider

Select a Provider optional

Rendering Provider Role

NPI

Service Provider 2

Select a Provider optional

Rendering Provider Role

NPI

Facility

Select a Provider optional

Rendering Provider Role

NPI

Back Next

6 Add any attachments and click Next

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender	
Eligibility Status	Group Number	Plan / Coverage Date	
Transaction Type	Organization	Payer	

ADD ATTACHMENT(S)

Add File

All applicable clinical information should be submitted with the original request. Timely submission of clinical documentation is key in avoiding delays in processing your requests.

Attachments may be up to 90MB in size, but the total of all attachments cannot exceed 150MB. Do not upload files which have embedded web links or information rights management. We will not be able to view them.

Back Next

7 Verify all information and hit Submit

1 Start an Authorization 2 Add Service Information 3 Rendering Provider/Facility 4 Add Attachments 5 Review and Submit

NGUYEN, SERGIO Patient

Member ID	Date of Birth	Gender	
Eligibility Status	Group Number	Plan / Coverage Date	
Transaction Type	Organization	Payer	

Member Information

Requesting Provider

Service Information

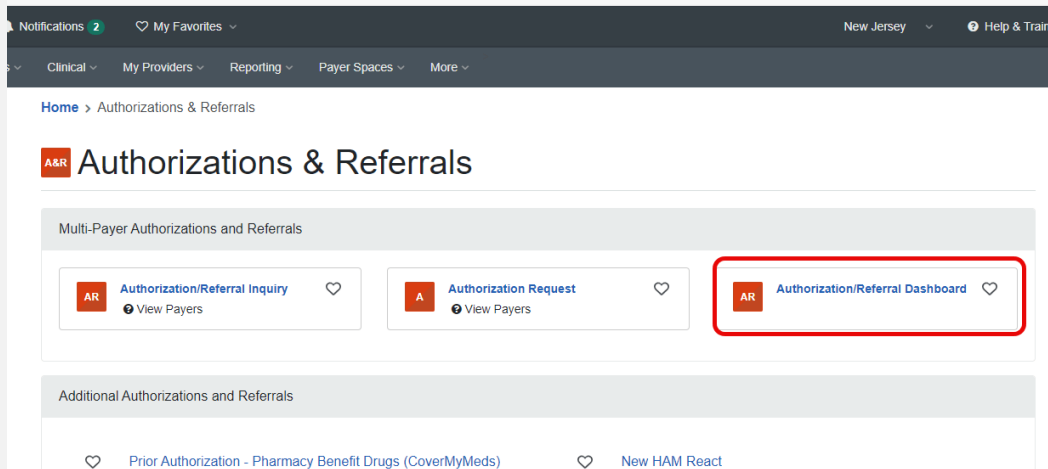
Rendering Provider/Facility

Attachment(s)

Back Submit

Checking Status of Authorizations Submitted via Availity

1. Click on Authorization/Referral Dashboard



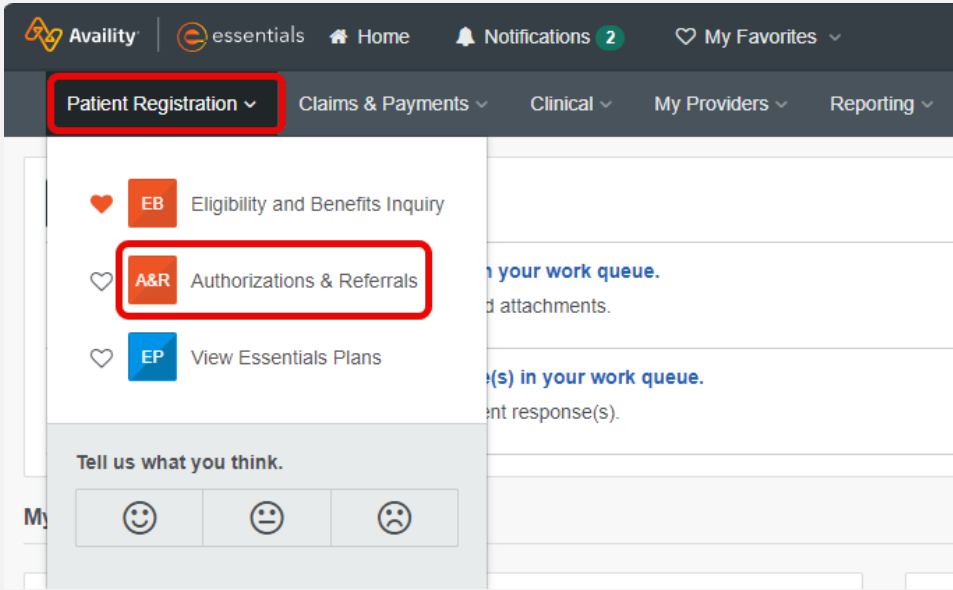
2. This will show status of those submitted in Availity only

The screenshot shows the 'Authorization/Referral Dashboard' table. The table has the following columns: Status / Last Updated, Certificate Number, Patient, Payer, Type, Submitted, and Actions. The table contains three rows of data, all from 'AETNA BETTER HEALTH FLORIDA'. The first two rows are 'Pending Review' (submitted 11/04/2024) and the third row is 'Denied' (submitted 11/04/2024). Each row includes a 'View Payers' link and a warning icon.

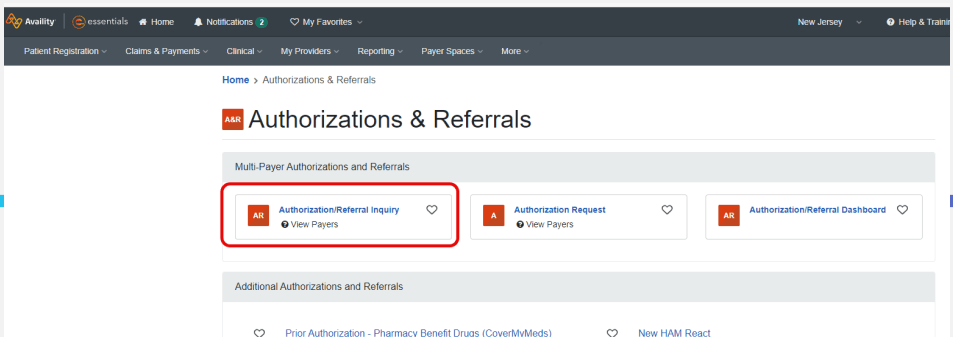
Status / Last Updated	Certificate Number	Patient	Payer	Type	Submitted	Actions
Pending Review Last week	[Redacted]	[Redacted]	AETNA BETTER HEALTH FLORIDA	Authorization Inpatient	11/04/2024	[Menu] [Star]
Pending Review Last week	[Redacted]	[Redacted]	AETNA BETTER HEALTH FLORIDA	Authorization Inpatient	11/04/2024	[Menu] [Star]
Denied Last week	[Redacted]	[Redacted]	AETNA BETTER HEALTH FLORIDA	Authorization Outpatient	11/04/2024	[Menu] [Star]

Authorization Inquiries

1 Once the provider is logged in, go to patient registration and authorizations & referrals.



2 For inquiries, select Authorization/Referral Inquiry



3 Enter all applicable data that has an asterisk *. Then click submit

4 Once you click submit, the auth information will populate.

Fidelis Care | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- [Fidelis Care provider portal](#)

Call or Fax:

- **Behavioral Health Phone:** 888-453-2534
- **Outpatient Auth Request Submissions:** 888-339-2677
(fax)
- **Inpatient Auth Request Submissions:** 855-703-8082 (fax)
- [Authorization Forms](#)

How providers will be notified of MH PA decisions:

- Decisions sent back to provider via fax
 - If there is no fax number, there will be telephonic outreach

SUD Prior Authorizations through

Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- Decisions sent back to provider via fax
 - If there is no fax number, there will be telephonic outreach

Criteria to determine medical necessity: InterQual, ASAM

To determine if a service requires authorization see our website: <https://www.fideliscarenj.com/en/New-Jersey/Providers/Authorization-Lookup>

Fidelis Care MH PA requests using our portal

Availity Essentials- Live 12/1/2025

POPULATION HEALTH & CLINICAL OPERATIONS

Availity Essentials Portal Home Page

Provider's access within their portal account may vary by their role within their organization or market/ state.

Main Toolbar

Notifications and Reminders

Top applications

News and Announcements

Account Dashboard

Carousel Ad

Submit PA using Fidelis Care Availity Portal
[secure online provider portal.](#)



Provider Registration — Availity Portal

BEFORE YOU BEGIN

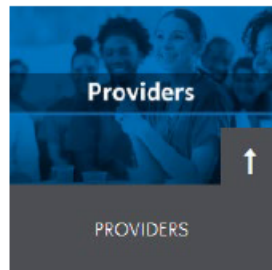
Gather this information about yourself and your organization:

- Physical and billing addresses
- Tax ID (EIN or SSN)
- NPI (if you have one)
- Primary specialty/taxonomy
- Check or EFT information from a health plan that you submit to (**recommended**)

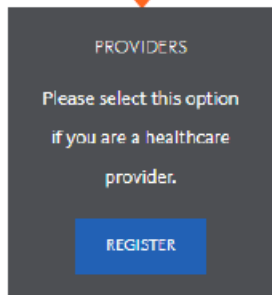
BEGIN REGISTRATION

1. Go to www.availity.com and click **REGISTER** at the top of the page.
2. Hover the cursor over the **Providers** tile, and then click **REGISTER**.
3. Complete the selection for a new user, accept the agreement terms, and then click **Sign Up**.
 - Are you already an existing user?
 - If you are, then select **Yes, I have an Availity User ID**.
 - Enter your credentials, accept the terms, and click **Sign Up** to create a new account.
4. Enter and confirm your email address and personal information to set up your account. Click **Next**.

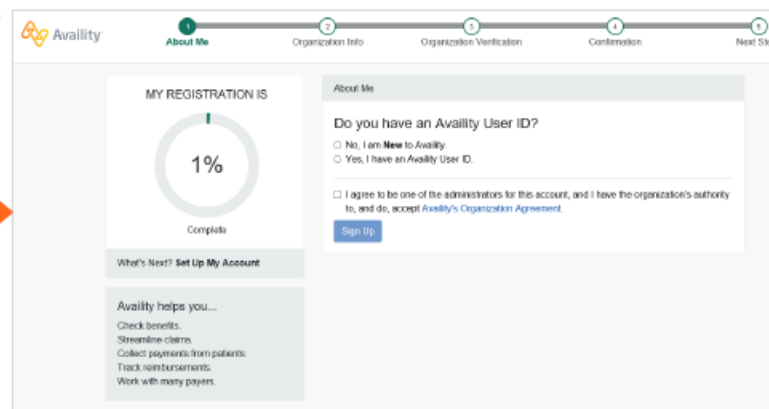
1



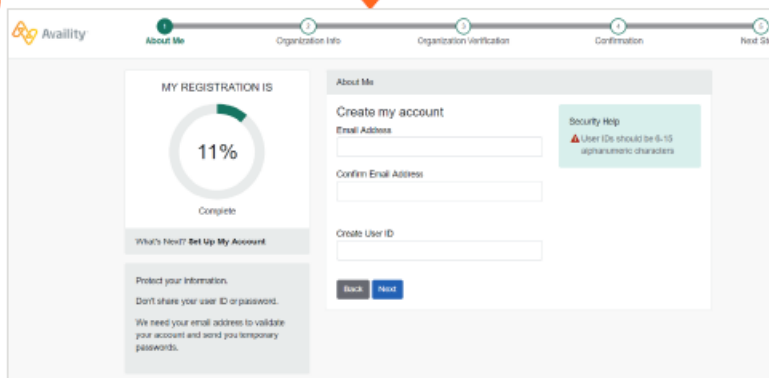
2



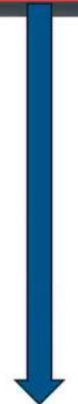
3



4



Note: User IDs should be 6-15 letters or numbers. On the second About Me page, make sure you enter your full legal name.



- Eligibility and Benefits Inquiry
- Authorizations & Referrals
 - Auth Request
 - Auth Inquiry
 - Auth Dashboard

Authorization: Key Information for Providers

- ☑ **Select the correct Authorization Type**
(Inpatient or Outpatient) to avoid cancellations or voided requests.
- ☑ **Always review Canon or Banner messages**
when displayed for helpful submission guidance.
- ☑ **Include additional information**
not captured in Availity fields as attachments or in the optional notes.

InterQual (IQ) Review

Providers can complete an IQ Review (when applicable) during the authorization submission process.

- Completing and submitting an IQ review (when applicable) in Availity is optional.

IQ Review completed in Availity migrates as a PDF attachments to the Health Plan's clinical documentation system.

Attachments

Providers can upload attachments through the Availity Essentials portal:

-> With the initial authorization submission

-> And while the authorization is in a pending (i.e., open/ not determined) status

Up to 10 files (64MB total) can be attached. Multiple formats allowed.

Upon determination of an authorization, providers can no longer submit additional documentation via the Availity Essentials portal.

Submitted attachments will be stored in document storage and a link or file will be added to the authorization in the Health Plan's documentation system, mirroring the current process.

Notes

Providers can add notes during the authorization submission process.

- Adding Notes is optional.
- Providers may use the optional notes field to include any relevant information that is not captured in the standard fields (e.g., BH/SUD, pharmacy, etc.) of the authorization submission.

Information entered by provider in the Notes field in Availity will populate in the Health Plan's clinical documentation system within the authorization under the Notes

Provider Not found - Availity Essential Portal Authorization Submission



For Provider not found in the Availity portal:

- Provider can manually enter the following required information within Availity: Name, NPI, address, phone number, fax number, a contact name and contact number.
- The information entered manually will come over to the health plan's documentation system within an **Auth note** or **Note Text** or **Availity message**.
- In the clinical documentation system: placeholder values like SP99, SP99X or 88888 will appear in the provider section.

UM staff will review the note received and manually update the provider information in the clinical documentation system.



Non-Par Provider Authorizations

Providers will be able to submit authorization requests in Availity Essentials for non-par providers that are not found in the initial Availity search, and/or are not contracted with Centene.

- The clinical documentation system will display an **Auth Note** or **Note Text** or **Availity message** that contains the non-par provider information and the non-par reason (Continuity of Care, Court Ordered Treatment, No Admitting Privileges at Par Facility, Patient Out of Area, Patient Request, Service Not Available in Network).

UM staff will follow the existing non-par authorization process for the next steps when completing requests for non-par providers.

Retrospective (Retro) Authorization Request Submissions

Acceptable Time Frame

Up to 30 days post service

Retrospective Reason

Required

Request Type

Mapped based on the line-item details submitted

Request outside of Acceptable Time Frame

Generates message in Availity, if an attempt is made outside of 30 days post service

Authorization Updates (Effective 08/18/2025)

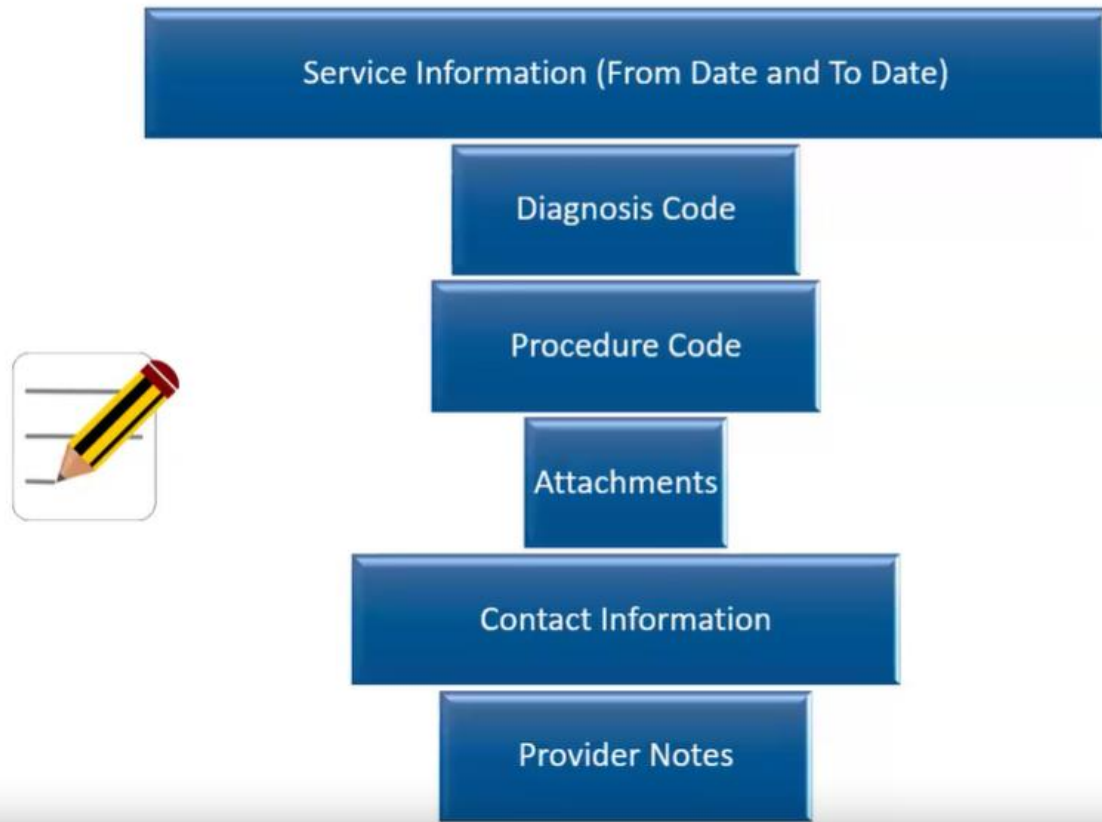
Outpatient (OP) Authorizations

- Updates allowed **only for submitted OP auths with a pended status**
- Updates limited to **specific fields** (*see next slide*)
- Use **“Update” button** on Authorization Dashboard
- Applies only to **OP auths migrated to TruCare and CareCentral** (*Excludes Fidelis - future release*)

Inpatient(IP) Authorizations

- **Update feature not available** via the Availity Portal at this time
- Providers must contact the Health Plan
- **UM staff** at Health Plan will follow existing IP updates process

Fields allowed to be updated in Availity for Outpatient Authorization Requests Only



To learn more about Outpatient Authorization Update feature available for providers in the Availity portal: Click [here](#) to watch a microlearning video (Password: AvailityLearning!)

Internal Use Only – This video is confidential and must not be shared with external parties (e.g., providers, vendors, or partners)



Authorization Updates (continued)

Continued Stay Reviews Process:

As providers **cannot update a determined inpatient authorization** including adding lines to an authorization already submitted when identified that the member has not discharged as planned and/or additional days are needed:

-> Providers will be directed to fax clinical documentation to the appropriate fax number of the Health Plan until new functionality becomes available.

Additional Notes on Authorization Updates

Authorization Status Change

Any updates (by provider or Health Plan) will update status of the request to **"Modified"** in the Availity Essentials portal

Voiding Authorizations

Providers **cannot void** auths from within the Availity Essentials portal

Must **contact Health Plan** to request voiding

If voided by the Health Plan, auth status will display as **"Cancelled"** in Availity

Authorization Status



Providers can view **authorization status*** (including the **determination**) via the following applications on the Availity portal:

- Authorization Dashboard
- Authorization/ Referral Inquiry

Applies to **most authorizations submitted through the portal (exceptions apply), regardless of the payer*

Effective 08/18/2025:

Expanded search functionality available on the portal:

- Search by NPI + Auth Number
- Search by Member + Provider
- Multi-auth search now supported (previously was limited to single auth search by Auth Number)

Horizon NJ Health | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- [Availity](#)

Call or Fax:

- **Phone:** 1-800-682-9094
- **Outpatient Fax (ECT/TMS/Routing OP Services):** 855-241-8895
- **PA Fax (IP/RES/PHP):** 732-938-1375

How providers will be notified of MH PA decisions:

- Providers can check outcomes of submitted PA requests via Horizon's CareAffiliate, which can be accessed through Availity
- In addition, providers will also receive a fax or mailed notice of determination letter for each prior authorization request

SUD Prior Authorizations through

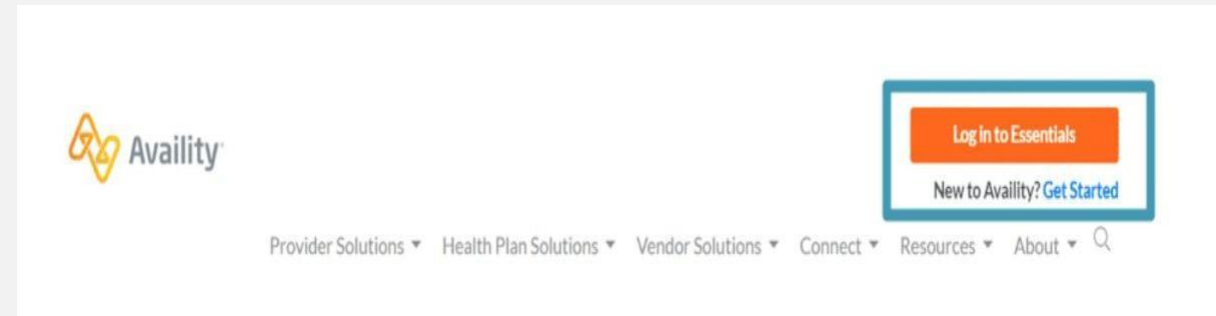
Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- SUD PA requests submitted through NJSAMS are loaded into Availity; therefore, providers can check outcomes of submitted SUD PA requests via the portal
- In addition, providers will also receive a fax or mailed notice of determination letter for each prior authorization request

Horizon NJ Health MH PA requests using Horizon's portal



Submit PA using Availity Portal

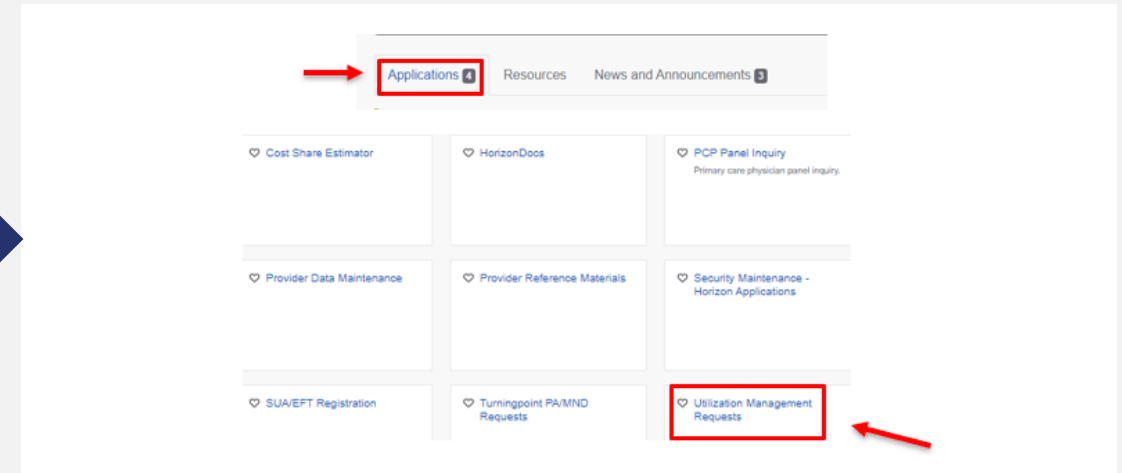
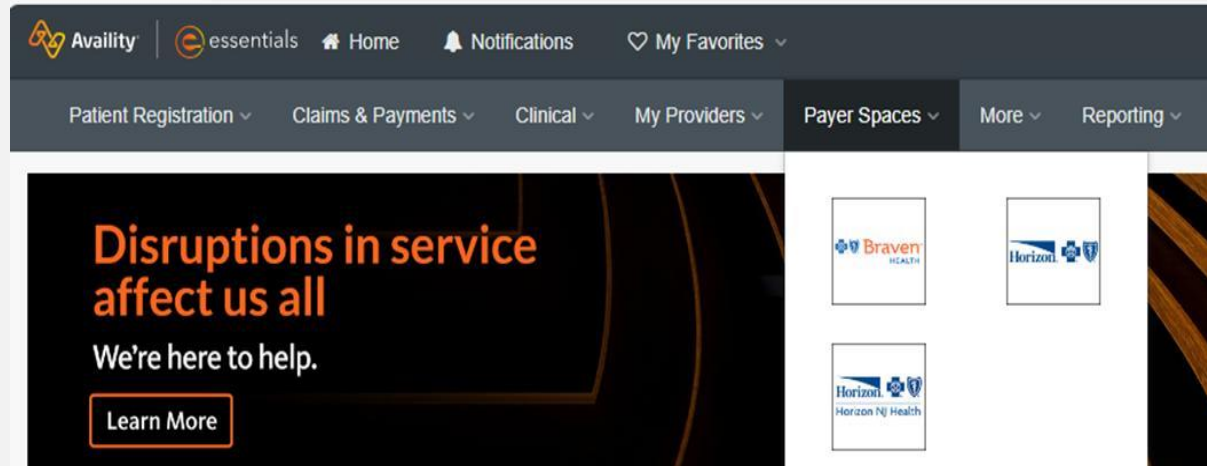
<https://availity.com/>

Learn about the Utilization Management Request
Tool Enhancements

[Self Study Guide](#)

[UM Tool Training Module](#)

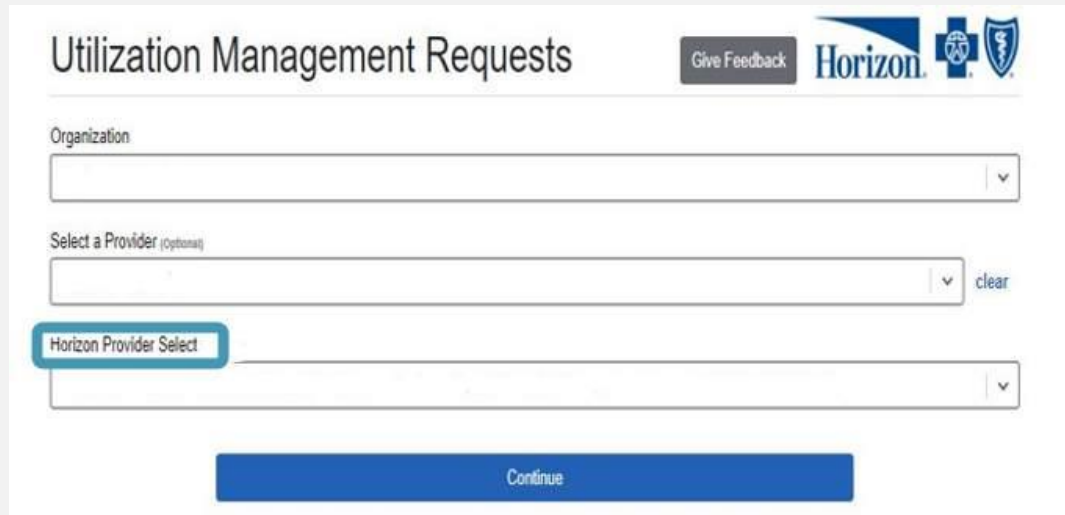
Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



Once logged into Avality, Click Payer Spaces dropdown and select plan type for member you are requesting services for.

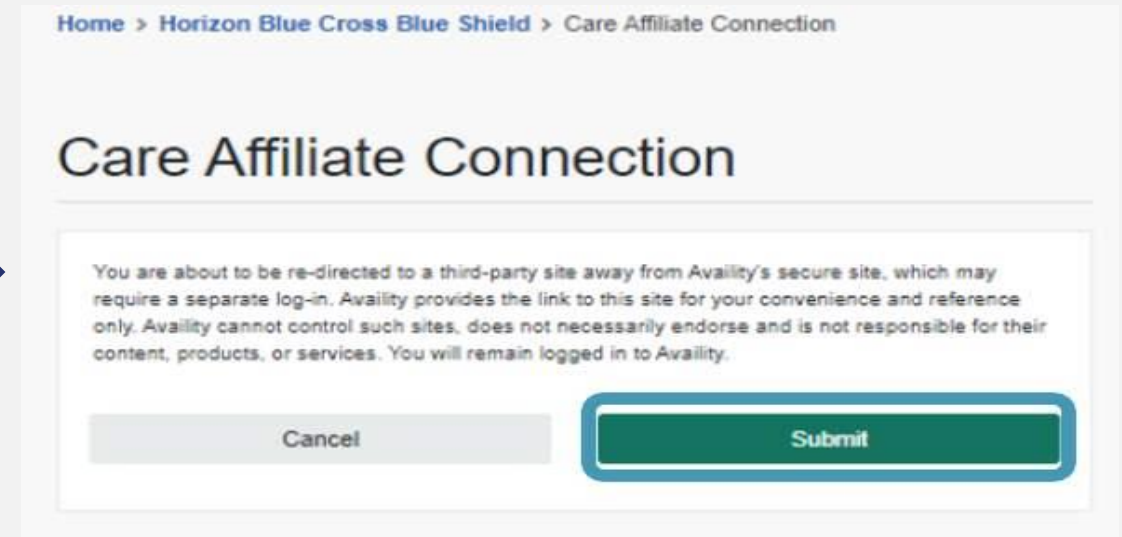
Scroll within Applications tab to Utilization Management Requests and click.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



The screenshot shows the 'Utilization Management Requests' page. At the top right, there is a 'Give Feedback' button and the Horizon logo. The main form contains three dropdown menus: 'Organization', 'Select a Provider (optional)', and 'Horizon Provider Select'. A blue 'Continue' button is located at the bottom of the form.

Once you click Utilization Management Requests, you will need to select your organization and complete "Horizon Provider Select" field. Click continue.



The screenshot shows the 'Care Affiliate Connection' screen. At the top, there is a breadcrumb trail: 'Home > Horizon Blue Cross Blue Shield > Care Affiliate Connection'. The main heading is 'Care Affiliate Connection'. Below the heading, there is a text box with the following message: 'You are about to be re-directed to a third-party site away from Availity's secure site, which may require a separate log-in. Availity provides the link to this site for your convenience and reference only. Availity cannot control such sites, does not necessarily endorse and is not responsible for their content, products, or services. You will remain logged in to Availity.' At the bottom, there are two buttons: a grey 'Cancel' button and a green 'Submit' button.

This screen advises that you that you will be re-directed to a platform called CareAffiliate. Click Submit to proceed.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal



Within CareAffiliate, from the Home tab, click the yellow Look Up button.

You will then see this screen. You can search by Member Name or Member ID.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

Member Search

Member ID: 2469533
Name: SCHMIDTXUAT, PAYNE
Look Up

Search Results

- Appeals (0) [New](#)
- Authorizations (4) [New](#)**
- Referrals (0) [New](#)
- Care Plans (0)
- Member Messages (0)
- Last Member Message(s) Received: N/A



General Information

Member ID: 9400878
Name: HARMANXUAT, MAXSON
Request Type: Begin typing to search favorites

Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility
Requesting Group
 Use for all Requested Services



Request Type Selection

Request Type Description
Containing Procedure: Begin typing to search favorites
Containing Specialty
 Show Inpatient Only
 Show Behavioral Health / Substance Abuse only
Search Clear Cancel

Once member has been found, an authorization can be initiated. Click the New button next to Authorizations option. *Note, if you click the Authorizations link, it will bring up prior submitted requests for selected member.

This step allows for entering request type selection. Click magnifying glass next to Request Type. A search box will populate. Click check box next to Show Behavioral Health/Substance Abuse Only, and hit Search. Then scroll through the list of options and select an option.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

General Information

Member ID: 9400878
Name: HARMANXUAT, MAXSON
Request Type: Inpatient Psychiatric
Event Classification: Urgent Concurrent
Case Type: Inpatient
Plan Valid for Services From: [] To: []
Plan: (None)

Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility: []
Requesting Group: []
 Use for all Requested Services



Individual Provider Search

ID Type: NPI
ID: []
First Name: []
Last Name: []

Institutional Provider Search

ID Type: (None)
ID: []
Name: []

Additional search criteria



Requester

Contact Name: horizon, test
Contact Phone: 714-5399999
Requesting Provider/Facility: 1001632907-81840283 - CAVICCHIA XUAT
Requesting Group: []
 Use for all Requested Services

Diagnoses

Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description
Diagnosis	Code	Description

Next, enter 90-day date span under Plan Valid for Services From and To, which will prompt a benefit/eligibility check. Then, click on magnifying glass next to Requesting Provider/Facility or Requesting Group.

Search box will open. Fill in ID type and ID information, and hit Search. Choose the correct option through the search results.

Diagnosis codes can now be added. Click magnifying glass next to description, and search by F code. Up to 4 diagnoses can be entered in this section.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

Authorizations

Authorization Request

Service 1
Inpatient Hospital/
Psychiatric - Inpatient

Notes (0)

Assessment (0)

Attachments (0)

General Information

Member ID: 9400878

Name: HARMANXUAT, MAXSON

Request Type: Inpatient Psychiatric

Event Classification: Urgent Concurrent

Case Type: Inpatient

Plan Valid for Services From: 10/01/2024 To: 12/31/2024

Plan: PREFERRED PROVIDER ORGA

Requester

Status Reason: Electronic Submission

Place of Service: Inpatient Hospital

Service: Psychiatric - Inpatient

Service From: []

To: []

Provider: []

Group: []

Facility: []

Provider Role: Attending

Actual Date Admitted: []

Admitting Diagnosis: []

Actual Discharge Date: []

Discharge Diagnosis: []

Disposition: (None)

Provider Location Search

Individual Provider Search

ID Type: [None]

ID: []

First Name: []

Last Name: []

Institutional Provider Search

ID Type: [None]

ID: []

Name: []

Additional search criteria

Address: []

City: []

State: []

Postal Code: []

County: []

Search within: [None]

Specialty: []

Provider Type: [None]

Network: [None]

Referral: ALL

Date: []

Medical ID: []

Search Clear Cancel

To initiate adding a service, click Service 1 in the Authorization Request box in upper left side of page.

When entering dates of service, they must fall within 90 day date span that was initially entered. Click Magnifying glass for Provider, Group or Facility, and repeat provider search steps previously described by searching individual or institutional provider. This time, you must enter rendering provider's information.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

Procedure Low

Procedure High

Quantity (None)

Total



Procedure Search

Procedure Type: Any

Code: Any

Description:

Gender: Both

Age: 36

Type	Code	Site Defined	Description	Gender	Min Age	Max Age
There are no records to display.						



Procedure Low

Procedure High

Modifiers

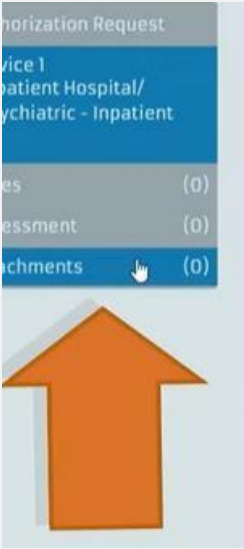
Quantity (None)

Total

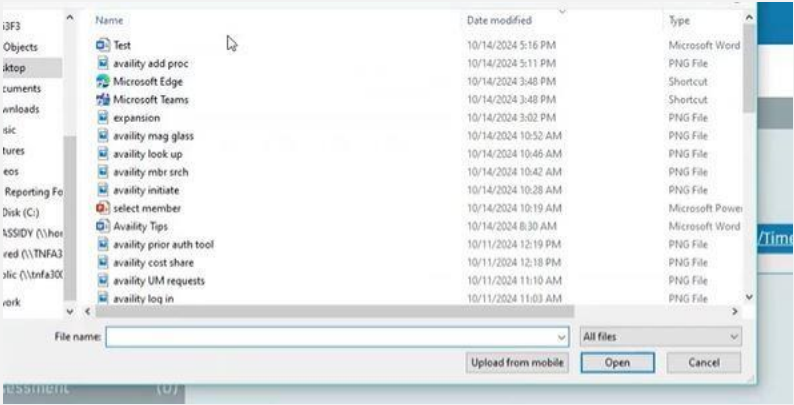
Next, procedure information should be added only for outpatient levels of care. Click add procedure tab toward bottom right of screen. A new window will open. Click magnifying glass next to Procedure Low to open search window.

Open drop down menu next to Procedure type. Make your selection and enter code. Click Search. You will be back at Add Procedure page. Procedure Low and High will be populated. Next, enter number of units requesting in Quantity field. Click drop down to right to select units. Then Click Add. *Note, if needing to add additional procedures, scroll up and click orange Copy Service Line.

Horizon NJ Health | How to submit MH PA requests using Horizon's Portal

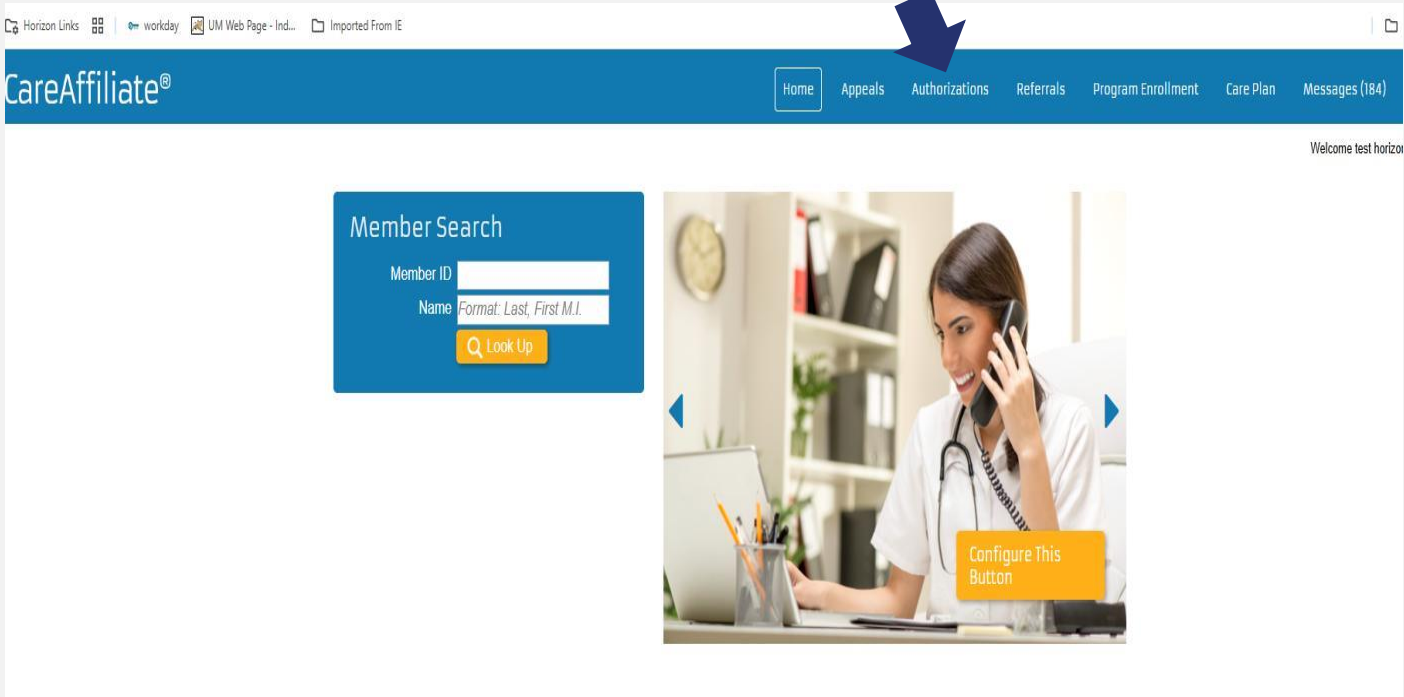


To add clinical information, attachments of clinical records can be added. Click add attachments in top left and then add file in the top right.



Double click on the file to be attached and then click upload file. A status of Attached appears when files are uploaded successfully.

Horizon NJ Health | How to check status of MH and SUD PA requests in Horizon's portal



On the Home Screen, go to Authorizations section for Mental Health and Substance Use Disorders.

Horizon NJ Health | How to check status of MH and SUD PA requests in Horizon's portal

Authorizations

Search Existing Records

Search Criteria

Member ID: [] Name: [Format: Last, First M.I.]

Requesting Provider ID: [] Name: [e.g.: Last, First M.I.]

Requesting Group ID: [] Name: [e.g.: Last, First M.I.] Location: []

Service Dates From: [] To: []

Submission Dates From: [] To: []

Status: (Any)

Reference #: 0001416926

Vendor Delegate Auth #: []

Diagnosis: [Code] [Description]

Procedure: [Begin typing to search favorites]

Place of Service: (Any)

Service: []

Service Dates From: [] To: []

Submission Dates From: [] To: []

Status: (Any)

Input the Reference number given on initial submission and click on "Search Existing Records."

Immediately you can review the Status. To get additional details, click onto the Reference number.

Reference #	Authorization #	Member ID	Member Name	Member DOB	Status	Diagnosis
0001416926		9400878	HARMANXUAT, MAXSON	10/01/1988	Not Certified	F32.9 : MDD, single episode, unspecified

Return To Search

Authorization Request

Service 1 - (Denied) Free-standing Psychiatric Facility/ Psychiatric - Inpatient

Notes (0)

Assessment (1)

Attachments (3)

General Information

Member ID: 9400878

Name: HARMANXUAT, MAXSON

Request Type: Psych Facility - IP

Event Classification: Urgent Pre service

Case Type: Inpatient

Plan Valid for Services From: 01/01/2023 To: 12/31/9999

Plan: PREFERRED PROVIDER ORGANIZATION

Requester

Contact Name: horizon, test

Contact Phone: 714-5399999

Requesting Provider/Facility: I1209100P13574300000001721676 - CAVICCHIAUAT, TAYANA K

Diagnoses

Diagnosis: ICD10 - F32.9 - Major depressive disorder, single episode, unspecified

To review documentation about decision, go to "Attachments." Once in Attachments, letters are hyperlinked and viewable.

*Note: In order to get a print-out of the request and status, you can print screen.

UnitedHealthcare | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- Provider Express: [Optum - Provider Express Home](#)

Call:

- 1-888-362-3368 (found on back of member's ID card)
- Follow the below system prompts:
 - Enter TIN #
 - Select option 3 (intake)
 - Enter member ID/DOB
 - Select option for "Mental Health"

How providers will be notified of MH PA decisions:

- PA decisions will be available in Provider Express if provider submitted the original PA via the portal
- PA requests submitted telephonically will be communicated via phone in real time
- In addition, providers will also receive a letter with a decision

SUD Prior Authorizations through

Additional information guidance:

- UHCCPNJ receives authorization requests via NJSAMS, which is a one-way communication system. We cannot send any information back to the provider via this one-way communication system.
- Its important to have a current and updated contact at the facility/org.
- Once authorization is given by UHCCPNJ BH based on an NJSAMS submission, the provider can view that authorization in Provider Express.com.

Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

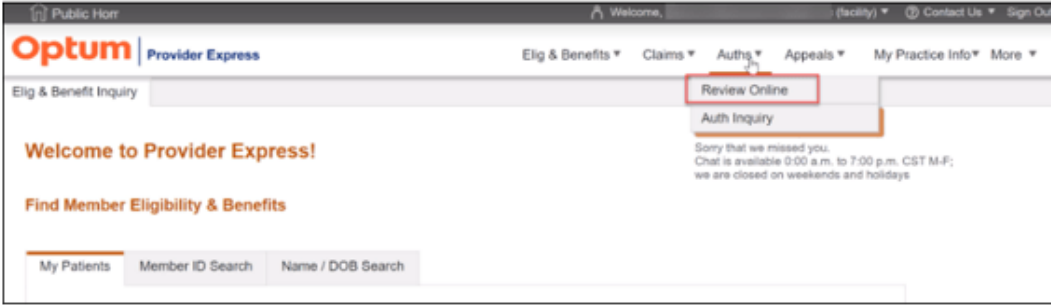
- Decisions sent back to provider via phone call
- SUD PA requests submitted through NJSAMS are also loaded into Provider Express; therefore, providers can check outcomes of submitted SUD PA requests via the portal

UnitedHealthcare MH PA requests using our portal

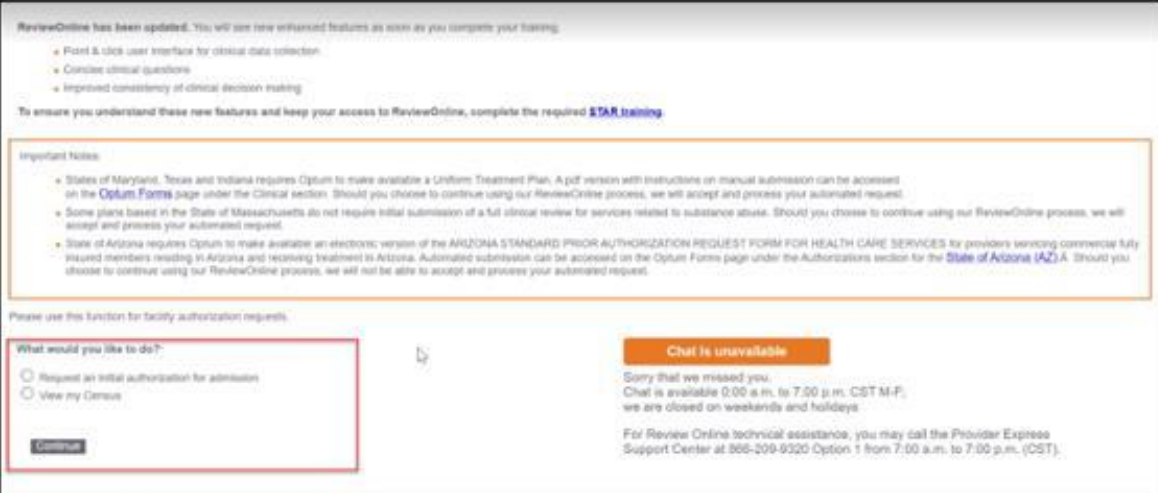


Submit PA using Providerexpress.com
[Optum - Provider Express Home](#)

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Step	Action
1	Providers will sign into Provider Express. https://public.providerexpress.com/content/ope-provexpr/us/en.html
2	Click on Auths in the top right-hand corner and select Review Online . 

3	<p>Now, there are two options for the provider at this point. Providers can</p> <ul style="list-style-type: none"> • Request an initial authorization for admission • View their Census - This takes you to a list of all of the facilities, patients and admit status. The Census page will show if an action is required or just the status of where the authorization is. Providers can also click on the Census option for Concurrent Review.
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ReviewOnline has been updated. You will see new enhanced features as soon as you complete your training.

- Point & click user interface for clinical data collection.
- Concise clinical questions.
- Improved consistency of clinical decision making.

To ensure you understand these new features and keep your access to ReviewOnline, complete the required **STAR training**.

Important Notes:

- States of Maryland, Texas and Indiana requires Optum to make available a Uniform Treatment Plan. A pdf version with instructions on manual submission can be accessed on the **Optum Forms** page under the Clinical section. Should you choose to continue using our ReviewOnline process, we will accept and process your automated request.
- Some plans based in the State of Massachusetts do not require initial submission of a full abstract review for services related to substance abuse. Should you choose to continue using our ReviewOnline process, we will accept and process your automated request.
- State of Arizona requires Optum to make available an electronic version of the ARIZONA STANDARD PRIOR AUTHORIZATION REQUEST FORM FOR HEALTH CARE SERVICES for providers serving commercial fully insured members residing in Arizona and receiving treatment in Arizona. Automated submission can be accessed on the Optum Forms page under the Authorizations section for the **State of Arizona (AZ)**. Should you choose to continue using our ReviewOnline process, we will not be able to accept and process your automated request.

Please use this function for facility authorization requests.

What would you like to do?

Request an initial authorization for admission

View my Census

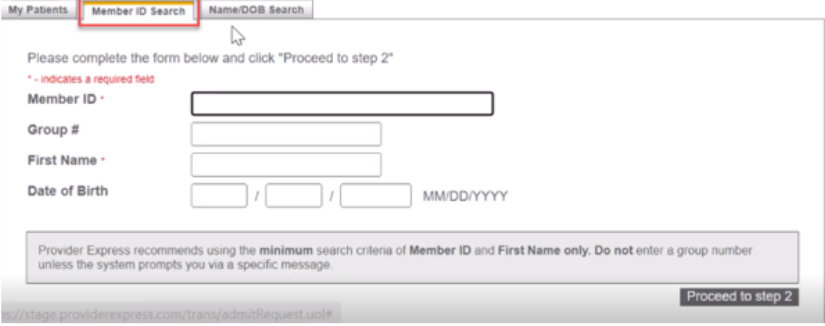
Continue

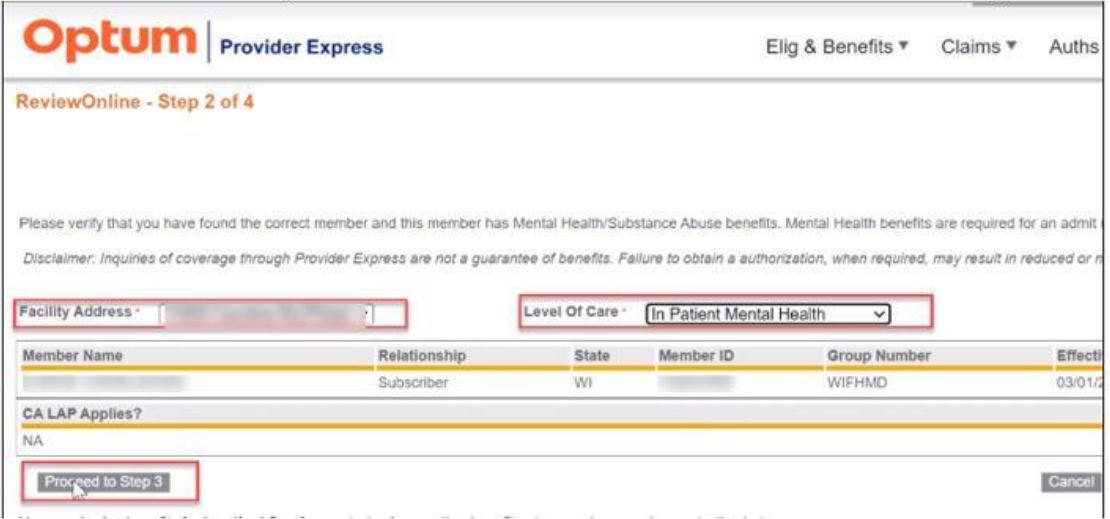
Chat is unavailable

Sorry that we missed you.
Chat is available 0:00 a.m. to 7:00 p.m. CST M-F;
we are closed on weekends and holidays.

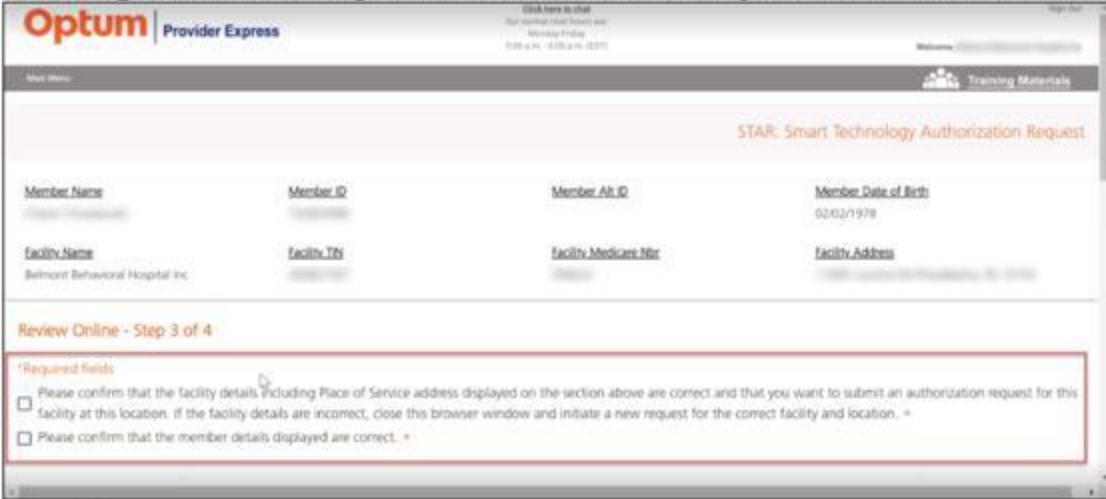
For Review Online technical assistance, you may call the Provider Express Support Center at 866-209-9325 Option 1 from 7:00 a.m. to 7:00 p.m. (CST).

UnitedHealthcare

Step	Action
1	<p>The provider will land on the ReviewOnline- On this page providers can locate a member 3 different ways.</p> <p>a. Member ID Search – search by Member ID.</p> 
2	Select Proceed to step 2 at the bottom of the page.

3	<p>This takes the provider to the ReviewOnline-Step 2 of 4. On this page the provider will select the Facility Address and Level of Care. Select Proceed to Step 3.</p>  <p>Optum Provider Express Elig & Benefits ▾ Claims ▾ Auths</p> <p>ReviewOnline - Step 2 of 4</p> <p>Please verify that you have found the correct member and this member has Mental Health/Substance Abuse benefits. Mental Health benefits are required for an admit <small>Disclaimer: Inquiries of coverage through Provider Express are not a guarantee of benefits. Failure to obtain a authorization, when required, may result in reduced or no</small></p> <p>Facility Address: [Dropdown] Level Of Care: [In Patient Mental Health ▾]</p> <table border="1"> <thead> <tr> <th>Member Name</th> <th>Relationship</th> <th>State</th> <th>Member ID</th> <th>Group Number</th> <th>Effecti</th> </tr> </thead> <tbody> <tr> <td>[Redacted]</td> <td>Subscriber</td> <td>WI</td> <td>[Redacted]</td> <td>WIFHMD</td> <td>03/01/2</td> </tr> </tbody> </table> <p>CA LAP Applies? NA</p> <p>Proceed to Step 3 Cancel</p>	Member Name	Relationship	State	Member ID	Group Number	Effecti	[Redacted]	Subscriber	WI	[Redacted]	WIFHMD	03/01/2
Member Name	Relationship	State	Member ID	Group Number	Effecti								
[Redacted]	Subscriber	WI	[Redacted]	WIFHMD	03/01/2								

UnitedHealthcare

Step	Action
4	<p>This takes the provider to the ReviewOnline-Step 3 of 4. On this page begin answering the initial set of questions to confirm the facility and member information.</p>  <p>The screenshot shows the 'Review Online - Step 3 of 4' page. It features a header with the Optum logo and 'Provider Express'. Below the header, there's a section titled 'STAR: Smart Technology Authorization Request'. The form contains several fields: Member Name, Member ID, Member Alt ID, Member Date of Birth, Facility Name, Facility TIN, Facility Medicare ID, and Facility Address. A red box highlights the 'Required fields' section, which contains two checkboxes: one for confirming facility details and another for confirming member details.</p>

- Enter the diagnosis
- Pick the Level of Care
- Answer the following questions
 - **Involuntary admission?**
 - **Is this request from an ER?**
 - **Member admitted?**
 - **Admit date**
 - **Has the member been discharged from the current episode of care?**

Select **Next**.

- 5 On the next page the provider will see a popup reminder letting the provider know that *The Draft is Saved. Incomplete drafts will be removed in 72 hours and no authorization will be created.*
- Select **OK**.

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Step	Action
6	<p>On the next page the Provider will complete all of the required information in the following sections</p> <ul style="list-style-type: none">• Member Information• Admission Information• Attending MD• Utilization Reviewer• Current Symptoms and Severity.• Risks <p>• Proposed Treatment</p> <p>• Discharge Planning</p> <p>• Attestation</p> <p>Note: Fields with a red asterisk are required.</p> <p>Click Next.</p>

7	<p>On the next page the provider will see the Confirmation pop-up. The pop-up will provide the following</p> <ul style="list-style-type: none">• Authorization number• Number of days the level of care has been approved for <div data-bbox="1465 625 2466 1225"><p>Confirmation</p><p>Thank you for your submission. Your authorization # is unknown</p><p>5 days have been approved for Inpatient.</p><ul style="list-style-type: none">• Please allow 1-2 hours for the authorization to be visible in your facility's census.• To request a level of care change, complete the Discharge online and initiate a new online request for the next level of care• To request additional days at the concurrent level of care, select "Concurrent" under the Action column for this member.• Medicaid Only: if this request is for court ordered treatment, please submit a copy of the court order via fax to 800-322-9104<p>Please note this authorization is not a guarantee of payment. Coverage is still subject to all terms and conditions of the member's benefit plan.</p><p>Authorizations apply only to services covered under the member's benefit plan, administered by Optum. Please call the number on the back of the member's ID card if you have questions.</p><p>OK</p></div>
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UnitedHealthcare MH Partial Care PA

Electronic Submission – MH Partial Care

- Electronic Prior Authorization for partial care mental health can be submitted through Provider Express. To access the request form, go to: Providerexpress.com > Our Network > State-Specific Provider Information > New Jersey > [Authorization Template](#)
- Complete the online request form.
- Use the “Attesting Individual’s Email Address” to track where the request is in the authorization process.

Wellpoint | Additional MCO-specific guidance for submitting MH and SUD PAs

MH Prior Authorizations

Where to submit MH PA requests:

Provider portal (preferred method):

- Availity Portal (access [here](#))

Call or Fax:

- **Inpatient Medicaid, PHP, IOP, and all Urgent Services:**
844-451-2794 (*fax*)
- **Inpatient Medicare, PHP, IOP, and and Urgent Services:**
844-430-1702 (*fax*)
- **Access Fax Forms Here:**
 - [Forms | Wellpoint New Jersey, Inc.](#)
- **Call:** 833-731-2149

How providers will be notified of MH PA decisions:

- PA decisions will be available in Availity if provider submitted the original PA via the portal
- PA requests submitted telephonically or by fax will be communicated via phone call or fax

SUD Prior Authorizations through

Additional information guidance:

- Its important to have a current and updated contact at the facility – both phone and fax numbers are important.

Where to submit SUD PA requests:

- Submitted through **NJSAMS**

How providers will be notified of SUD PA decisions:

- Decisions communicated to provider via fax or phone call

Wellpoint MH PA requests using our portal

The screenshot shows the Availity portal interface. The top navigation bar includes 'Patient Registration', 'Claims & Payments', 'Clinical', 'My Providers', 'Payer Spaces', 'More', and 'Reporting'. A red circle '1' highlights the 'Patient Registration' menu item. Below the navigation bar, the 'Authorizations & Referrals' section is visible. A red circle '2' highlights the 'Authorizations & Referrals' menu item in the left sidebar. In the main content area, there are several cards: 'Authorization/Referral Inquiry', 'Authorization/Referral Dashboard', 'Authorization Request' (with a red circle '3' highlighting it), and 'Referral Request'. Each card has a 'View Payers' link. Below the main content area, there is a section for 'Additional Authorizations and Referrals' with links for 'Premera Code Check (including Premera and its suite of plans)', 'New Authorization/Referral Dashboard', and '(CoverMyMeds)'.

1. Select Patient Registration in the top navigation bar.
2. Select Authorizations & Referrals
3. Select Authorization Request.

Submit PA using Availity Portal
[\(access here\)](#)

Note – recent issue submitting PA via portal will be fixed by March 17th.
Please use fax until that date

