



## Alcohol (Ethanol) Testing

### **MEDICAL NECESSITY CRITERIA (OMHSAS-approved)**

In order for a non-breath alcohol test to be approved as medically necessary, the following two criteria must be met:

1. The member requires alcohol testing in order to establish or to exclude a diagnosis of alcohol intoxication, abuse, or dependence in order to guide treatment.
2. The member's current clinical status prevents the use of a breath alcohol test

**ALCOHOL (ETHANOL) TESTING AUTHORIZATION REQUEST**

(Please print legibly/type)

Member Name \_\_\_\_\_ Date of Request \_\_\_\_\_

MA CIS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc Sec# \_\_\_\_\_

Agency Name \_\_\_\_\_ CBH provider # \_\_\_\_\_ Fax # \_\_\_\_\_

Physician Requesting Name \_\_\_\_\_ Position/Title \_\_\_\_\_ Phone# \_\_\_\_\_

Laboratory Name \_\_\_\_\_ Phone # \_\_\_\_\_

DSM Diagnoses (give complete diagnostic category name including specifiers, if relevant):

\_\_\_\_\_

1. Amount of alcohol consumed daily? \_\_\_\_\_

2. Date of last alcohol use? \_\_\_\_\_

3. Please indicate clinical rationale as to why an alcohol breath test may not be utilized:

\_\_\_\_\_

**CBH USE ONLY**

Date Received \_\_\_\_\_ Received by \_\_\_\_\_

Comment:

\_\_\_\_\_

\_\_\_\_\_

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Approved? \_\_\_ Yes \_\_\_ No

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