PRIOR AUTHORIZATION FORM: Mental Health Residential Treatment or Partial Hospitalization Program Continued Stay Request

This form is for Mental Health Residential Treatment or Partial Hospitalization Program continued stays. Clinical for concurrent review must be received no later than 24 hours prior to the last covered day. **ALL QUESTIONS MUST BE ANSWERED.**

FAX this form to 1-855-407-5688

RTC PHP

Member Name: Today's Date:

DOB: **ID:** Time:

Facility Name:

NPI/TIN:

UR Name:

Phone:

Does the member have other insurance? Yes No

If yes, Name:

Address:

Phone:

Date ROI requested from family/guardian/proxy (must attach a copy):

UDS (if co-occurring):

Current DX (and any additional):

Mental status exam at each review (attach evaluation):

Meds changes – additions, discontinuations (date/time/dose/frequency). One line per medication:

Is the member medication-compliant and is there improvement?
(Provide evidence supporting noted improvement if any):

List any new medical concerns/side-effects/allergies/precautions:

Frequency of psychiatric/medication evaluation (must occur at least once weekly; attach MD/ARNP notes):

Who has been identified as the member's support in the community?
Describe their involvement in member's treatment:

TREATMENT PLAN

Provide goals in **SMART** format. Be **S**pecific, noting each goal. How will the goal be **M**easured, or monitored in a quantifiable way? It must be **A**ttainable and **R**ealistic for the individual's circumstances. It must be **T**ime-specific, so the member knows how long reaching the goal should take.

Was the member involved in **updating** the treatment plan? (Include specifics):

Was the family involved in **updating** the treatment plan? (Include specifics):

What is the progress on each goal? (Must attach notes):

How many individual/group/family sessions has the member attended in the past week?
(Must attach notes to include date, time, duration and outcome):

Provide any additional information pertinent to your request for additional days:

Anticipated LOS:

Attending doctor/ARNP:

Phone:

DISCHARGE PLAN UPDATE

(Must provide specific updated information at each review. Provide evidence of all referrals made.
Must include name of practitioner/agency, appointment date/time. Attach supporting documentation below.)

DCP/CM/SW Name:

Phone:

UR Name:

Phone:

Number of requested additional days: