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

This form is for Mental Health Residential Treatment or Partial Hospitalization Program stays. It is to be completed prior to admission into residential or partial hospitalization facilities. When a member is stepping down directly from an inpatient hospital or CSU stay, the request for authorization must be called in. 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: Physician Order Date: Time:

UR Name:

Phone:

Does the member have other insurance? ○ Yes ○ No

If yes, Name:

Address:

Phone:

If the member is a minor, guardian/CPS caseworker name:

Phone:

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

Voluntary or Involuntary (Baker Act/Ex-parte) (must attach a copy):

If this is NOT a planned admission, **STOP! YOU MUST CALL IN!**

Pregnant? ○ Yes ○ No How many weeks?

OB Name:

Phone:

Specific/comprehensive reason for admission:

Admitting UDS (if co-occurring):

Admitting DX (and any additional):

Mental status exam (attach evaluation):

List all current meds & compliance (one line per med):

List NEW meds initiated at admission (date/time/dose/frequency):

Current medical concerns/allergies/precautions:

Cultural considerations (language, religious, sexual orientation):

Anticipated LOS:

Attending Doctor/ARNP:

Phone:

HISTORY

H/O trauma:

H/O education/employment/legal:

H/O family SUD or MH:

H/O all prior inpatient, residential and PHP treatment (include provider, date/duration and outcome):

H/O all outpatient treatment (include provider, date/duration and outcome):

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 developing the treatment plan? (Include specifics):

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

What are program days/and time?

Is transportation available? (Include specifics)

DISCHARGE PLAN

Provide anticipated discharge needs, referral sources, special requests:

DCP/CM/SW Name:

Phone:

UR Name:

Phone:

Number of requested days: