PRIOR AUTHORIZATION FORM: Substance Abuse Disorder (SUD) Residential Treatment or Partial Hospitalization Program Extended Stay Request

This form is for SUD 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 ARF stay, the request for authorization must be received within 24 hours of the discharge. 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 member have other insurance? ◯ Yes ◯ No

If yes, Name:

Address:

Phone:

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

ASAM criteria level:

UDS/BAL:

Current DX (and any additional):

CIWA/COWS/ withdrawal SX/Vitals:

Meds changes – additions, discontinuations (date/time/dose/frequency):

Compliance/response:

New medical concerns/allergies/precautions:

Stage of change:

Motivation for change:

Anticipated LOS:

Attending Doctor Name:

Phone:

- Provide treatment plan and progress (MUST be **SMART** goals):
  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 Time-specific, so the member knows how long reaching the goal should take.

- Provide summary of individual, group and family therapy notes for the TX period (must provide date/time/frequency/outcome):

- Provide specific information on the family's involvement:

- Provide doctor's notes (must include date/time/frequency/outcome):

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

- Is MAT being considered prior to and post-discharge? ◯ Yes ◯ No
  Where will the member receive follow-up care/MAT?

- Provide evidence of referrals to AA/NA or other support groups such as SMART or Celebrate Recovery:

- Is the member being assisted with locating a sponsor? ◯ Yes ◯ No
  Has one been located? ◯ Yes ◯ No

DISCHARGE PLAN UPDATE

(Must provide specific updated information at each review. Attach supporting documentation below.)

DCP/CM/SW Name:
Phone:

UR Name:
Phone:

Number of requested additional days: