Aetna	**Sunflower Health Plan**	**UnitedHealthcare**
Fax: 1-855-225-4102	Fax: 1-844-824-7705	Fax: 1-855-268-9392

KanCare Service Authorization Form

Services May Be Requested When 75% of Authorized Units Have Been Utilized And/Or 14 Days In Advance of Authorization Expiration

PATIENT

Name _____ Medicaid ID # _____ DOB _____

PROVIDER *Individual and/or Group*

Name _____ City _____ Phone # _____ Tax ID # _____

Address _____ State _____ Zip _____ Fax # _____ Agency NPI # _____

Current ICD Diagnosis

Primary _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

MEMBER STATUS

☐ SED

☐ PRE

☐ SPMI

☐ Not Applicable

MEDICAL CONDITONS *as Reported by Patient*

☐ None ☐ Chronic Pain

☐ Asthma/COPD ☐ Dementia

☐ Cancer ☐ Diabetes

☐ Cardiovascular Problems ☐ Obesity

☐ Smoking/Tobacco Use ☐ Other _____

CURRENT RISK ASSESSMENT

Suicide Risk: ☐ Ideation ☐ Plan ☐ Intent ☐ Hx of harming self ☐ N/A

Homicide Risk: ☐ Ideation ☐ Plan ☐ Intent ☐ Hx of harming others ☐ N/A

If any checked, indicate safety plan (or attach): _____

MEDICATIONS PRESCRIBED BY PROVIDER

Medication Name	Dosage	Medication Name	Dosage	Medication Name	Dosage

If mood or psychotic disorder is present and no medications are prescribed, please explain: _____

COORDINATION OF CARE

Coordination has occurred with:

☐ PCP ☐ Specialist ☐ Psychiatrist ☐ Therapist ☐ N/A

PSYCHIATRIC TREATMENT HISTORY

☐ Inpatient: ☐ Within past yr ☐ 1- 3 yrs ago ☐ 3 yrs or more

☐ PRTF: ☐ Within past yr ☐ 1- 3 yrs ago ☐ 3 yrs or more

☐ No Treatment History

SYMPTOMS and FUNCTIONAL IMPAIRMENT *If present, check degree* On Disability: ☐ Yes ☐ No

	Mild	Mod.	Severe		Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	☐	☐	☐	Hopelessness	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐
Decreased Energy	☐	☐	☐	ADLs	☐	☐	☐	Significant Weight Change	☐	☐	☐
Delusions	☐	☐	☐	Family/Relationships	☐	☐	☐	Panic Attacks	☐	☐	☐
Depressed Mood	☐	☐	☐	Inattention	☐	☐	☐	Sleep Disturbance	☐	☐	☐
Hallucinations	☐	☐	☐	Irritability/Mood instability	☐	☐	☐	Physical Health	☐	☐	☐
Hyperactivity	☐	☐	☐	Impulsivity	☐	☐	☐	Work/School	☐	☐	☐

SERVICES BEING REQUESTED

	Units Requested		Units Requested
☐ Psychiatric Diagnostic Interview (Intake)	_____	☐ Peer Support	_____
☐ Individual Therapy	_____	☐ Psychosocial Rehab Individual	_____
☐ Family Therapy	_____	☐ Psychosocial Group	_____
☐ In-Home Family Therapy	_____	☐ Attendant Care 1915(b)	_____
☐ Group Therapy	_____	☐ TCM	_____
☐ Case Conference	_____	☐ Other: _____	_____
☐ Crisis Intervention	_____	☐ Other: _____	_____
☐ CPST	_____	☐ Other: _____	_____

Summarize the goal(s) being addressed and the criteria for measuring achievement of the goal(s) or attach copy of current Treatment Plan: _____

Patient agrees with treatment goals: ☐ Yes ☐ No

TREATMENT PROGRESS

Level of improvement to date: ☐ Minor ☐ Moderate ☐ Major ☐ Maintenance tx of chronic condition

☐ No progress to date, indicate how treatment will be adjusted to address: _____

Authorization requested for _____ days Start date for new authorization: _____

_____	_____
Staff Name	***Date***