Psychiatric Residential Treatment Facilities Prior Authorization Request

Amerigroup Kansas, Inc.
Fax: 1-877-434-7578

Sunflower Health Plan
Fax: 1-844-824-7705

United Healthcare/OptumHealth
Fax: 1-855-268-9392

Member information

Member name: ________________________________

Medicaid/ID number: ____________________________

Member DOB: _________________________________

Other health insurance: ❒ yes ❒ no

If yes, please list carrier(s)/policy number(s):

____

Member's current living situation: ________________

Member's current custody status: _________________

Name of parent/legal guardian: __________________

Phone number for parent/legal guardian: ___________

Current mailing address for parent/legal guardian:

____

Referring concern/presenting problem

Statement of concern:

Current behavioral health diagnoses: ____

Primary: ____

Secondary: ____

Dual diagnosis (i.e., intellectual disability, autism spectrum, substance abuse): ______________________________

Current medications: ____

Discharge plan if the child meets this level of care

Medical services

____

_ Behavioral services

____

_ Educational needs

____

_ Developmental needs

____

_ Psychosocial needs

____

_ Legal needs

____

Behaviors/symptoms of concern

(Mark all that apply to indicate acuity and chronicity of behaviors. Provide detail of behavior and frequency in text box.) Homicidal ideation/threat/attempt: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

____

Physical/verbal aggression toward others/animals: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

____

Suicidal ideation/intent/plan/attempt: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

____

Self-injurious behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

____

Symptoms of mood disorder: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Substance use/addiction: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Self-care failure: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Runaway behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Risky sexual behaviors/human trafficking: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Sexually inappropriate/aggressive/abusive behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Trauma exposure/abuse/neglect history: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Anorectic/bulimic/binge eating/food hoarding behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Fire setting/property destruction: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Hallucinations/delusions/other psychotic symptoms: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Recent stressors contributing to behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Repeated arrests or confirmed illegal activity: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Other behaviors/symptoms of concern: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days

Current treatment/support services (utilized with less than 30 days)

Please select all that apply:

☐ Intensive outpatient program; frequency: ______________________________
☐ Substance abuse treatment — residential; frequency: ______________________________
☐ Substance abuse treatment — outpatient; frequency: ______________________________
☐ Serious emotional disturbance waiver; frequency: ______________________________
☐ Community-based services; frequency: ______________________________
☐ Therapy (i.e., individual, family, group); frequency: ______________________________
☐ Medication management; frequency: ______________________________
☐ Family preservation; frequency: ______________________________
☐ Intellectual/developmental disability services; frequency: ______________________________

If member currently receives services from a community mental health center (CMHC), please identify the CMHC, the service(s) and length of time engaged in services:

Current physical health conditions/concerns

☐ Pregnant — number of weeks:
☐ Diabetes — insulin dependent: ❒ yes ❒ no
☐ History of traumatic brain injury
☐ Seizure disorder:
☐ Other (please describe):

Inpatient/residential treatment history

Please select all that apply:
☐ Inpatient psychiatry; dates if known:
☐ Psychiatric residential treatment facilities (PRTFs); dates if known:
☐ Substance abuse treatment — residential; dates if known:

Educational history

Currently in school: ❒ yes ❒ no
Current grade level: ______________________________
Alternative school: ______________________________
Current individual education plan/504 plan: ______________________________
Other school-based services/supports: ❒ yes ❒ no; If yes, please describe: ______________________________
Full scale intelligence quotient (if known): ______________________________
Other relevant educational history: ______________________________

Placement history less than 60 days

____

Other services that could be provided upon diversion

____

Official justification for decision

____

Treatment team's goals for PRTF treatment

____

Completed by:
Agency: ______________________________ Name/job title: ______________________________

Phone number: ______________________________ Date: ______________________________

Section to be completed by managed care organization (MCO)

Certification of Need for Services

Member's name:		**Date of birth:**	

MCO and medical director admission review

Yes	**No**	*Please select one choice for each item.*
☐	☐	1. Based on a review of the available medical documentation, ambulatory care resources available in the community do not meet treatment needs for the member.
☐	☐	2. The member's psychiatric condition, symptom severities and treatment plan meet medical necessity for psychiatric residential treatment facility care under the direction of a physician.
☐	☐	3. The services rendered can reasonably be expected to improve the member's condition **or** prevent further regression so that the services will no longer be needed.
☐	☐	4. I confirm that I have knowledge of the individual's situation based on review of the available medical documentation.

This determination was made by a team independent of the facility, including a physician with competence in the diagnosis and treatment of mental illness.

Medical director:	Date: