Psychiatric Residential Treatment Facilities Prior Authorization Request

Aetna	Sunflower Health Plan	United Healthcare/OptumHealth
Fax: 1-855-225-4102	Fax: 1-844-824-7705	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: