Psychiatric Residential Treatment Facility & Theraputic Group Home

FAXED INITIAL AUTHORIZATION REQUEST

Used to notify of initial/concurrent admission and to request authorization.

Instructions

- Complete this form in its entirety and submit within 24 hours of admission.
- Separate fax forms are required for each member and each request.
- You will receive a Notice of Coverage when approved, or contacted via phone if a peer-to-peer review is needed, within 24 hours (excluding weekends and holidays).
- If for some reason you do not receive a determination within 24 hours, call 1-866-595-8133.
- Once the member is discharged and no additional days are needed, fax the discharge to 1-866-698-6341 within 24 hours.

Submit by fax to:

1-866-698-6341

Retain a copy of the fax confirmation for your records.

Facility Information

Facility Name: PLEASE PRINT _____ UR Name: _____

Admission Date: _____ Target Admission Date: _____

Facility Tax ID: _____ UR Phone: _____

Facility NPI: _____

Facility Fax: _____

Service Location: _____

Member Information

Full Name: PLEASE PRINT _____ Admit Date: MM/DD/YYYY _____

Medicaid ID: _____ Admitted: □ Voluntary □ Involuntary

Birth Date: MM/DD/YYYY _____ Other Insurance: _____

Phone: _____ CSoC? □ Yes □ No

Guardian (if applicable): _____

DCFS worker name and contact (if applicable): _____

OJJ worker name and contact (if applicable): _____

Is this an out of state placement? □ Yes □ No

Has Interagency services coordination been approved? □ Yes □ No

Clinical Information

Mental Status Exam and Date: _____

Precipitating Event or Detox Issues leading to admission:

Date and Results of Urine Drug Screen:

ICD-10 Diagnosis code(s):

History of Audio/Visual hallucinations/delusions:

Has the child ever been a danger to others (e.g. threatening to kill or seriously injure another person, fighting to the point of serious injury, been accused of being sexually aggressive, or engaging in fire setting, possible runaway, have any unit restrictions? (include dates)

Treatment Plan:

Compliance with medications:

Family History with mental illness or substance abuse (please detail):

Family Support:

Past Medical History:

Developmental disabilities/ Autism spectrum disorders:

OCDD involvement: (include date and contact person)

Outpatient Treatment History (if applicable) :

If yes, please list OP Providers/Services/Date span:

IQ:

Past or current legal charges:

Education: (grade regular or special education and school performance):

Alcohol/Drug Use:

UDS:

Diagnosis:

Medications

Name	Dose/Frequency	Initiation
		☐ Prescribed prior to admission ☐ Initiated during this admission
		☐ Prescribed prior to admission ☐ Initiated during this admission

☐ Prescribed prior to admission
☐ Initiated during this admission

☐ Prescribed prior to admission
☐ Initiated during this admission

☐ Prescribed prior to admission
☐ Initiated during this admission

☐ Prescribed prior to admission
☐ Initiated during this admission

Side Effects (if any):

Blood levels:

Past 30 day update on behaviors and functioning:

All incidents of restraint/seclusion/self-harm/property destruction: (Include Date)

Current Precautions: (Include Status Date)

Last Doctor's note and date:

Last nurse's note and date:

Last Group Therapy note/ date/ frequency:

Last Family Therapy note and date:

Last contact with DCFS work: (what was discussed?)

Last contact with OJJ worker: (what was discussed?)

Last contact with other parties involved (CASA):

Last Individual therapy note/date/frequency: (Include therapist name)

Additional Therapy and date: (Please note type and frequency)

Peer interaction:

Staff interaction:

Coordination and Discharge Planning

Current School Performance in PRTF:

Treatment Plan (include dates of any updates):

Discharge Plan:

Any barriers to successful discharge? (please detail):

CSoC referral needed: (reminder CSoC referral can be made 90 day before discharge)

CSoC referral date: (if applicable)

CSoC Screening

Eligibility

Is member between ages 5-20? (If "No", skip the remaining CSoC Screening questions.)	□ Yes □ No
DSM-V diagnosis?	□ Yes □ No
Currently receiving FFT, MST, or Homebuilders?	□ Yes □ No

Appropriateness

Has the child ever talked about or actually tried to hurt him/herself or acted in a way that might be dangerous to him/her?	□ Yes □ No □ Unknown
Has the child ever been a danger to others (e.g. threatening to kill or seriously injure another person, fighting to the point of serious injury, been accused of being sexually aggressive, or engaging in fire setting, possible runaway, have any unit restrictions)?	□ Yes □ No □ Unknown
Has the child deliberately or purposefully behaved in a way that has gotten him/her in trouble with the authorities such as breaking the rules at school or laws in your community?	□ Yes □ No □ Unknown

Estimated DC Date:

If Sent to Physician Advisor Review for Not Meeting Medical Necessity

□ **By notes only**

□ **Peer to Peer** (complete below)

Attending Physician:

Phone number: _____ Best time to call: _____