Psychiatric Residential Treatment Facilities Prior Authorization Request

Amerigroup Kansas, Inc.	Sunflower Health Plan/Cenpatico	United Healthcare/OptumHealth
Fax: 1-877-434-7578	Fax: 1-866-535-6974	Fax: 1-855-268-9392

Member information

Member name: Select here to enter text.
Medicaid/ID number: Select here to enter text.
Member DOB: Select here to enter text.
Other health insurance: yes/no
If yes, please list carrier(s)/policy number(s): Select here to enter text.
Member's current living situation: Choose an item.
Member's current custody status: Choose an item.
Name of parent/legal guardian: Select here to enter text.
Phone number for parent/legal guardian: Select here to enter text.
Current mailing address for parent/legal guardian: Select here to enter text.

Referring concern/presenting problem

Statement of concern: Select here to enter text.
Current behavioral health diagnoses: Select here to enter text.
Primary: Select here to enter text.
Secondary: Select here to enter text.
Dual diagnosis (i.e., intellectual disability, autism spectrum, substance abuse): Select here to enter text.
Current medications: Select here to enter text.

Discharge Plan if the child meets this level of care

Medical Services
Select here to enter text.
Behavioral Services
Select here to enter text.
Educational Needs
Select here to enter text.
Developmental Needs
Select here to enter text.
Psychosocial Needs
Select here to enter text.
Legal Needs
Select here to enter text.

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
Select here to enter text.

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
Select here to enter text.

Self-injurious behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Symptoms of mood disorder: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Substance use/addiction: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Self-care failure: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Runaway behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Risky sexual behaviors/human trafficking: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Sexually inappropriate/aggressive/abusive behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Trauma exposure/abuse/neglect history: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Anorectic/bulimic/binge eating/food hoarding behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days Select here to enter text.

Fire setting/property destruction: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Hallucinations/delusions/other psychotic symptoms: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Recent stressors contributing to behaviors: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

Repeated arrests or confirmed illegal activity: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days Select here to enter text.

Other behaviors/symptoms of concern: ☐ Within 60 days ☐ Within 60-180 days ☐ Within 180+ days
Select here to enter text.

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

Please select all that apply:

- ☐ Intensive outpatient program; frequency: Select here to enter text.
- ☐ Substance abuse treatment — residential; frequency: Select here to enter text.
- ☐ Substance abuse treatment — outpatient; frequency: Select here to enter text.
- ☐ Serious emotional disturbance waiver; frequency: Select here to enter text.
- ☐ Community-based services; frequency: Select here to enter text.
- ☐ Therapy (i.e., individual, family, group); frequency: Select here to enter text.

☐ Medication management; frequency: Select here to enter text.
☐ Family preservation; frequency: Select here to enter text.
☐ Intellectual/developmental disability services; frequency: Select here to enter text.

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: Choose an item.

Current physical health conditions/concerns

☐ Pregnant — number of weeks: Select here to enter text.
☐ Diabetes — insulin dependent: yes/no
☐ History of traumatic brain injury
☐ Seizure disorder: Select here to enter text.
☐ Other (please describe): Select here to enter text.

Inpatient/residential treatment history

Please select all that apply:

☐ Inpatient psychiatry; dates if known: Select here to enter text.
☐ Psychiatric residential treatment facilities (PRTFs); dates if known: Select here to enter text.
☐ Substance abuse treatment — residential; dates if known: Select here to enter text.

Educational history

Currently in school:
Current grade level: Select here to enter text.
Alternative school:
Current individual education plan/504 plan:
Other school-based services/supports: ; If yes, please describe: Select here to enter text.
Full scale intelligence quotient (if known): Select here to enter text.
Other relevant educational history: Select here to enter text.

Placement history less than 60 days

Select here to enter text.

Other services that could be provided upon diversion

Select here to enter text.

Official justification for decision

Select here to enter text.

Treatment team's goals for PRTF treatment

Select here to enter text.

Completed by:
Agency: Select here to enter text. Name/job title: Select here to enter text.
Phone number: Select here to enter text. Date: Select here to enter a date.

Section to be completed by MCO

CERTIFICATION OF NEED FOR SERVICES

Member's Name:		**Date of Birth:**	

Managed Care Organization 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 severity, and treatment plan meets medical necessity for psychiatric residential treatment facility (PRTF) 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.

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