South Carolina School District - Name of School
Treatment Review & Authorization Request

☐ Initial Request- PA Form/ Clinical Assessment/IPOC ☐ Re-Authorization Request/PA Form/90 day Progress Summary

Admission Date: _____ Start Date of Services: _____ Date of Request: _____

Managed Care Organization				
☐ **Select Health** Phone: (866) 341-8765 Fax: (888) 796-5521	☐ **Blue Choice** Phone:(866) 902-1689-opt 2 Fax: (877) 664-1499	☐ **Molina** Fax: (866) 423-3889	☐ **Absolute Total Care** Fax: 866-912-3606	☐ **Wellcare** Crisis Fax: (888) 588-9842 Fax: (888) 343-5364

School District Contact Information Provider(s) Information			
School District Name:	**Address:**	**Medicaid Provider #:**	**NPI #:**
Billing Person Contact Name:			Phone #: Fax #:

LPHA Referral Contact Information	
LPHA (Contact):	Phone#:

Child's Information			
Child's Name:	Name on MCO/Insurance Card:	Date of Birth:	Medicaid#
Address:	Parent/Guardian Name:		Phone #:
Other Insurance – Name:	Member Number:		

Current Diagnoses

ICD-10 or DSM-5 or Z code:
Description:

Co-Occurring Disorder: ☐ **Yes** ☐ **No** ☐ **Define:**

Current Medications (medication name, dosage, frequency and prescriber): ☐ **None** ☐ **Yes**
List or attach medication orders, if applicable.

Treatment Request: please check services being requested for the RBHS program:

		Services	Frequency	Encounters/ Number of Units	Start Date of Services	Target End Date
☐	**96101**	**Psychological Testing and Evaluation**				
☐	**90832**	**Individual Psychotherapy - 30 min**				
☐	**90834**	**Individual Psychotherapy - 45 or more**				
☐	**90837**	**Individual Psychotherapy - 60 mins or more**				
☐	**90846**	**Family Psychotherapy without Patient**				
☐	**90847**	**Family Psychotherapy with Patient**				
☐	**90853**	**Group Psychotherapy**				
		Community Support Services				
☐	**H2014**	**Behavioral Modification**				
☐	**H2017**	**Psychosocial Rehabilitation Services – Individual**				

☐		☐ **Group** ☐				
☐	**S9482**	**Family Support**				

All MCOs require a prior authorization for continued services and Psychological Testing and Evaluation.

All services must meet medical necessity criteria to justify services. Risk Factors may interfere with the ability to function in daily living, personal relationships, school and recreational settings that assist in determining medical necessity for services or the need for an additional assessment.

To Re-Authorize Community Support Services, the child must meet all the following medical necessity criteria.

☐ The desired outcome(s) of services has not been met.

☐The family /caregiver/guardian is engaged in the treatment process.

☐ The child is at risk for out-of-home-placement.

Justification for Authorization: (Be specific about describing symptoms).

Date of onset of Symptoms:	Duration of Symptoms:

Describe symptoms or issues:

List previous Objective(s)	**Outcome /Progress / Achievement of the Objective(s)**

List **new objectives** to be prior authorized. List expected outcomes to improve the child behavior: (Briefly describe how client is likely to benefit from the services requested or purpose of the treatment in relation to expected outcomes)

List requested Objective (s)	**Purpose of the treatment and expected outcome(s)**

Previous and/or current Treatment history and Outcome: ☐ None ☐ Yes. See Initial Clinical Assessment

Discharge/Transition Plan: (90 Day progress summary) **Inpatient Admission in the last 90 days:** ☐ None ☐ Yes

Significant changes in member's life since last assessment- **Date of Last Assessment:**

☐ None. This is an initial request for services ☐ No significant changes

☐ Changes noted as follows:

Comments:

LPHA Print Name:	**Signature:**	**Date:**