FirstChoice
by Select Health of South Carolina
Your Hometown Health Plan

Healthy Connections

Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

The purpose of this form is to request authorization for admission to a psychiatric residential treatment facility (PRTF). This form should be sent to the Behavioral Health Utilization Management (BHUM) department only. Fax to **1-888-796-5521**. For any questions, please contact BHUM at **1-866-341-8765**.

Steps to request a PRTF authorization:

All PRTF authorizations are based on medical necessity of services. All PRTF authorizations require supporting clinical documentation to be submitted with the PRTF Authorization Request Form. All required clinical information is the responsibility of the referring or requesting provider to obtain and provide to Select Health of South Carolina (Select Health) BHUM for a medical necessity determination. Failure to submit all clinical documentation will delay processing this request.

1. The request must include the following documentation to be reviewed for medical necessity:
    a. Most recent psychosocial and/or diagnostic assessment by a licensed practitioner of the healing arts (LPHA) within the previous week.
    b. Court order for placement (if applicable).
    c. Most recent IEP/504 plan (if applicable).
    d. Psychological and/or neuropsychological testing (if applicable).
    e. Certificate of Need per 42 CFR 441.152.
2. Upon receiving all clinical information, Select Health BHUM will schedule a telephonic review to determine medical necessity. The telephonic review is required to include the member's LPHA who has completed a face-to-face assessment with the member.

Referral information		
Date of referral:	Referral contact:	
Referring facility/agency/provider:	Phone:	Fax:

Demographic information		
Child's name:	Date of birth:	Medicaid ID:
Ethnicity:	Language:	Diagnosis:
Home address:		Phone number:
City:	State:	ZIP code:
Custody (parents, DSS, other family, juvenile court, other agency):		
Name of custodian:	Relationship:	Phone number:

LPHA recommending a PRTF level of care	
Provider name:	Phone:
Contact person:	Phone:

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NPI/Tax ID number:	Fax:
Date the LPHA completed a face-to-face assessment/session with the member (required to be within seven calendar days of the Certificate of Need)?	
What is the member's current status or placement?	

Reason for referral

Current MH/SUD symptoms (frequency, dates, consequence that lead to a referral for PRTF):			
What are the contributing factors to the main clinical need/problem?			
What are the goals for the PRTF admission and recommended interventions to the contributing factors indicated above?			
Current living situation:			
Family's role in treatment:			
DSS, DJJ, legal, or other involvement? ☐ Yes ☐ No If yes, indicate type:		If so, contact name:	Phone number:
Child's current grade level:	Current school:	Special education classification? ☐ Yes ☐ No If yes, type:	

All medication	Dose	Schedule	Prescribing provider	Target symptons

A medical necessity determination will be made after a review of all required clinical information and a telephonic review. A medical necessity determination will be made within seven calendar days of Select Health BHUM receiving all required clinical documentation.