

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						
<input type="checkbox"/> Select Health Phone: (866) 341-8765 Fax: (888) 796-5521	<input type="checkbox"/> Blue Choice Phone:(866) 902-1689- opt 2 Fax: (877) 664-1499	<input type="checkbox"/> Molina Fax: (866) 423-3889	<input type="checkbox"/> Absolute Total Care Fax: 866-912-3606	<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Define:						
Current Medications (medication name, dosage, frequency and prescriber): <input type="checkbox"/> None <input type="checkbox"/> 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				

	<input type="checkbox"/> Group <input type="checkbox"/>				
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.					
<input type="checkbox"/> The desired outcome(s) of services has not been met.					
<input type="checkbox"/> The family /caregiver/guardian is engaged in the treatment process.					
<input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Yes. See Initial Clinical Assessment					
Discharge/Transition Plan: (90 Day progress summary) Inpatient Admission in the last 90 days: <input type="checkbox"/> None <input type="checkbox"/> Yes					
Significant changes in member's life since last assessment-			Date of Last Assessment:		
<input type="checkbox"/> None. This is an initial request for services			<input type="checkbox"/> No significant changes		
<input type="checkbox"/> Changes noted as follows:					
Comments:					
LPHA Print Name:			Signature:		Date: