PRIOR AUTHORIZATION REQUEST FOR CHILDREN AND ADOLESCENTS BHIF, BHRF & HCTC
FAX: (844) 424-3976

PLEASE TYPE ALL INFORMATION. NOTE THAT REQUEST** WILL **NOT BE ACCEPTED UNLESS COMPLETED IN DETAIL WITH ALL SUPPORTING INFORMATION ATTACHED.

Requested Level of Care: ☐ BHIF - 0124 ☐BHRF – H0018 ☐HCTC - S5109

Name: **DOB**:
AHCCCS #:
Current status: ☐T19 ☐NT19 - CMDP ☐other primary insurance/ T-19 2nd

Behavioral Health Diagnosis:

Treating Doctor/NP, Name and phone number:
Date of last Psychiatric appointment:

PNO/Clinic: **Requesting CM/ team lead name**:
Contact information for requestor: **email**: **Phone #:**
Fax#
Legal Guardian Name: ☐ Bio ☐ adoptive ☐foster ☐kinship ☐DCS
Who is making the request? ☐legal guardian ☐foster ☐DCS ☐DCS placement ☐cm/BHMP/hospital
Is this HB2442? ☐ yes ☐ no
Other members of CFT: ☐ DCS ☐JPO ☐DDD ☐ ALTC/ CRS

Current location of member: (*i.e. inpatient, foster care, group home, family*)
How long at this location:

Attach the following documents: absence of these documents will delay decision of this request. (check each box of documentation provided)

☐ Current medication sheet
☐ Last 3 CFT meeting notes
☐ Last 3 psychiatric provider progress notes
☐ Current service providers most recent progress note
☐ Any Psychological, Neuropsychological, Psychosexual testing that has occurred in the past year
☐ IEP or 504 from school

Diagnosis *including substance use /abuse/dependence: Please be detailed including developmental disability if applicable.*

1. 2. 3.

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Reason for Referral: (check all that apply)

☐ Self-harming behaviors ☐ Physical aggression
☐ Substance Use
☐ SMB
☐ Other describe:

Provide examples for each item checked above: *including specific, detailed symptoms/duration/recent legal history/ charges / stressors/ complicating issues* ***within the last 3 months***:

Current psychiatric and therapeutic services utilized within the last 90 days*: with frequency of each/ dates of service provided and effect? Please provide the last provider progress note*

Reason for Service	Type of service	Exact Dates of services	Outcome

2: **Functioning**:

Please describe changes or serious impairment of behaviors over the ***past 3 months*** *caused by psychiatric symptoms which are not responding to the above services or prevent outpatient services from being implemented. Please specifically identify*:

2a. Is the member in the following at school? (please check which applies)
☐regular class ☐IEP ☐ 504

3: **Expected improvement from this level of care requested**:

Behavior or symptoms requiring treatment	Goal level of functioning for discharge

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4. **Tentative Discharge Plan***: Aftercare plan to include recommendations from all members of team including treating MBHP,* plan *A and Plan B. Included where will patient reside after d/c from residential treatment and what treatment services will be provided***?**

Requesting clinician: SIGNATURE/ DATE_____

Supervisor Name: SIGNATURE/ DATE: _____

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THE FOLLOWING MUST BE COMPLETED BY PSYCHIATRIC PROVIDER OR MEDICAL DIRECTOR IF NOT ASSIGNED OR ASSIGNED PROVIDER IS NOT AVAILABLE.

BHMP recommendation:
I am (Check one) ☐ in agreement ☐ not in agreement for **Requested Level of Care**: ☐ BHIF ☐BHRF ☐HCTC

Clinical opinion/rationale (based on level of care criteria) of psychiatric provider for treatment request:

And/or if not in agreement

I am recommending the following services:

Printed Name of Provider or Medical Director:

Signature of provider: _____Date:_____