hor_307 WOODLAND HILLS SERVICE AREA

REQUEST FOR REAUTHORIZATION 16 or more

At 16 & all subsequent renewals, email this form to: **WH-OutsideMedicalCase-Management@kp.org**

**\*\*FORM IS DUE 7 DAYS PRIOR TO EXPIRATION OF CURRENT AUTHORIZATON\*\***

**\*\*Incomplete forms will be returned \*\* No retroactive authorization will be issued\*\***

|  |  |  |
| --- | --- | --- |
| Provider name: | Patient name: | Patient MRN: |
| Diagnosis (full descriptive term): | Icd10: | Patient DOB: |
| Authorization #: | Recommend Continued Treatment  Recommend Discharge | |
| Total # of sessions of ***this episode of care***     Was there a previous episode?     As needed, explain below. | | |
| Dates of service for current auth #, please list: | | |

**Outside Referral Dept update:**

1. Yes  No: Primary coverage is Medi-Cal
2. Yes  No: Diagnosis has been changed and needs to be updated in HealthConnect
3. Yes  No: TPI is actively integrated into treatment.

**Progress Summary**

1. Focus of Clinical Attention for this 10 session episode of care:

1. Describe measurable clinical/behavioral progress for session completed; what evidence do you and the patient observe? (TPI)

1. Patient participation in treatment:

Participates Actively Poor Compliance

Moderately Invested Other: Explain:

**Current Status**

1. Observed and reported **clinical symptoms** (reference DSM V) in last 2 weeks (specify acuity level of symptoms e.g, mild, moderate, severe). List should support diagnosis with specifiers. Recent TPI scores may support this section as well.

1. Describe level of **functioning in every day life** (including but not limited to activities of daily living: grooming, hygiene, eating, sleeping; ability to manage various roles: family, friend, employee, community member; ability to work or function in school; etc). Compare to the normal, functional baseline for this patient.

1. With continued treatment, how likely is it that the presenting mental health condition will improve? Why or why not? Compare to TPI trajectory, consult as needed with Clinical Liaison.

1. Describe and clarify **risk factors** if any (include and explain harm to self, harm to others, risk for decompensation or regression):

**Treatment Plan- Create with patient**

1. 2-3 agreed upon SMART goal(s) going forward:

*Specific, Measurable, Attainable, Realistic, Time-Limited*

1. Additional services/referrals recommended (medication evaluation, group therapy or workshop assessement, higher level of care assessment) – you must discuss with patient:

Provider Name and Group Practice name:

Provider Email and Phone:

Date: