OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name _____

Provider Name _____ Date Completed _____

Revised 4/2009

APS Healthcare, Inc.
4545 Lincoln Boulevard, Suite 103
800-762-1560 (Main) / 800-762-1639 (FAX)

FAX DATE: _____ TIME: _____

TYPE OF FAX: (Mark only ONE of the following)

☐ INITIAL REQUEST

☐ IMPORTANT NOTICE RESPONSE (Attention: Reviewer)

☐ EXTENSION REQUEST

☐ PENDING ELIGIBILITY RESPONSE (Attention: Reviewer)

☐ MODIFICATION REQUEST (Attention: Reviewer)

☐ PROVIDER CHANGE OF DEMOGRAPHIC INFORMATION (Attention: Clerical Staff)

☐ CORRECTION REQUEST (Attention: Reviewer)

☐ RECONSIDERATION REQUEST (Attention: Appeals Committee)

☐ OTHER _____

TO: APS – Medicaid Outpatient Preauthorization Unit ATTENTION: _____
FAX NUMBER: (405) 762-1639 (Reviewer)

FROM: FACILITY/AGENCY: _____

CONTACT NAME: _____

PROVIDER ID #: _____ CASE MGMT ID #: _____

Check One: Mental Health Request ☐ Substance Abuse / Integrated Request ☐

FACILITY ADDRESS: _____
Street City State Zip

FAX NUMBER: _____ PHONE NUMBER: _____

RE: CLIENT NAME: _____
First MI Last Designation (Sr., Jr., III, etc.)

RECIPIENT ID #: _____ PA #: _____
(If Applicable)

NUMBER OF PAGES INCLUDING THIS PAGE: _____

COMMENTS: (NO clinical information) _____

_____

_____

CONFIDENTIALITY

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION Date Completed: _____

Client Name:_____
First MI Last Designation (Sr., Jr., III, etc.)

Social Security # _____ **Legal Guardian Name: _____**
Relationship to Client: _____

Date of Birth: _____ Age: ____ Sex: ____
MM/DD/YY

Current Residence: (Check ALL that apply)
___Individual Home ___Residential Care Facility ___Group Home (Level_____) ___Nursing Home ___Shelter
___ICF/MR (Admit Date:_____) ___ DHS/OJA/IH Custody (Worker:_____ Phone#_____)
___Foster Care (Placement Date:_____) ___TFC Multiple placements in past 2 years (#_____)
LEVEL: ___ 1 ___2 ___3 ___4 ___Exceptional Case ___0-36 months ___ICF/MR ___RBMS

ADMIT DATE TO CURRENT FACILITY: _____
TREATMENT HISTORY: (Admit / Discharge dates, facility, IP or OP, reason for treatment)
_____

_____

_____

DSM-IV DIAGNOSES: (Complete ALL five axes)

Principal Axis I Code: _____ Title:_____

Second Axis I Code: _____ _____

_____ _____

Axis II Code: _____ _____

_____ _____

Axis III _____

_____

Axis IV: Problems related to: ___Primary support group ___ Social environment ___Education ___Housing ___Economic
___ Occupation ___ Access to health care services ___ Interaction with legal system/crime ___ Other _____

Axis V GAF: Current:_____ Highest Level in the Past Year:_____
HISTORICAL INFORMATION (relevant to current diagnosis and treatment): _____

_____

_____

_____

_____

_____

Client Name: _____ Date Completed: _____

CLIENT ASSESSMENT RECORD **Past** **Current**

1. FEELINGS/MOOD/AFFECT

Problem areas: ___Mood lability ___Coping skills ___Suicidal/homicidal ideation/plan ___Depression **SCORE** _____ _____
___Anger ___Anxiety ___Euphoria ___Change in appetite/sleep patterns
Evidenced by (specific examples, symptom frequency, duration and intensity, impact on daily functioning)_____

_____

_____

_____

2. THINKING/MENTAL PROCESS **SCORE** _____ _____

Oriented x _____ MMSE score (if administered) _____ IQ Score (if MR diagnosis) _____
Problem areas: ___Memory ___Cognitive process ___Concentration ___Judgment ___Obsessions
___Delusions/hallucinations ___Belief system ___Learning disabilities ___Impulse Control
Evidenced by (specific examples, symptom frequency, duration and intensity, impact on daily functioning)_____

_____

_____

_____

3. SUBSTANCE USE: **SCORE** _____ _____

Drug of Choice Amount Used Frequency of Use Age First Used Date Last used

_____

_____

_____

Functional impact of current use, give examples of level of dpendency_____

_____

_____

4. MEDICAL/PHYSICAL **SCORE** _____ _____

Current Medical/physical conditions_____

_____

_____

Impact/limitations on day-to-day function _____

_____

MEDICATIONS

Name of Rx Dosage/Frequency Reason for Rx

_____

_____

_____

_____

5. FAMILY **SCORE** _____ _____

Currently resides with ___ biological family ___adoptive family ___foster family ___Other_____
Problem areas: ___ Parenting ___Conflict ___Abuse/violence ___Communication ___Marital ___Sibling ___Parent/child
Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)_____

_____

_____

_____

Client Name: _____ Date Completed: _____

6. INTERPERSONAL **SCORE** **Past** _____ **Current** _____

Problem areas: ___Peers/friends ___Social interaction ___ Withdrawal ___Make/keep friends ___Conflict

Evidenced by (specific examples, frequency, duration, intensity, impact on daily functioning)_____

_____

_____

_____

7. ROLE PERFORMANCE **SCORE** _____ _____

Functional role: ___Employment/Volunteer ___School/daycare ___ Home management ___Other _____

Effectiveness of functioning in identified role _____

_____

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)_____

_____

_____

8. SOCIO-LEGAL **SCORE** _____ _____

Problem areas: ___Ability to follow rules/laws ___Authority issues ___Legal issues ___Aggression

___Probation/parole ___Abides by personal ethical/moral value system ___Antisocial behaviors

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)_____

_____

_____

9. SELF-CARE/BASIC NEEDS **SCORE** _____ _____

Problem areas: ___Hygiene ___Food ___Clothing ___Shelter ___Medical/dental needs ___Transportation

Evidenced by (specific examples, frequency, duration and intensity, impact on daily functioning)_____

_____

_____

COMMUNICATION (required for ICF/MR level of care) ___ESL ___Hearing impaired ___Non-verbal

___Uses interpreter ___Signs ___Uses mechanical device ___Speech impaired ___Fluency

Descriptors:

_____

_____

INTERPRETIVE SUMMARY/ADDITIONAL INFORMATION: _____

_____

_____

_____

_____

_____

_____

Client Name: _____ Date Completed: _____

I/We (client/guardian) have actively participated in the development of this service plan and understand the treatment goals and objectives listed. I have the following comments/response:

_____

I/We (___Agree) (___Disagree) with this service plan.

_____ _____
Client Signature, 14 or older Date Parent/Guardian Signature Date

Witness: _____ Relationship to client: _____

If client is unable to sign, document the reason:_____

TREATMENT TEAM:

_____ _____
*Responsible MHP or AODTP Signature, Degree/License Date Physician, Credentials Date

____Physician signature not required

* ____ All required signatures are on file and available for audit. Printed name and licensure required if not signing on PA request.

Type of Service Frequency of Service Print Staff Name & Credentials Signature Date

Ind Psy _____

Int Psy _____

Grp Psy _____

Fam Psy _____

P/S Reh-G _____

P/S Reh-I _____

A/D Skill Dev-G _____

A/D Skill Dev-I _____

Psy Test _____

Med T/S _____

CM _____

BH Aid _____

_____

_____

OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

(R-04-03-09)

Recipient ID #:_____ **Provider #:**_____

Start Date:

SERVICES REQUESTED
(pick only one)

☐ **PG001 – Prevention & Recovery Maintenance**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG002 – Level 1 OP ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG003 – Level 2 OP (includes 0-36 mo)**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG004 – Level 3 OP ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG008 – Level 4 OP ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG015 – Level 4 OP Intensive In home - Child Systems of Care Only**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG019 – ICF/MR ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG031 – RBMS ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG025 – Exceptional Case – one month only**

SUBMIT THIS FORM ALONG WITH THE
OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION FORM

Client Name: _____ Date Completed: _____

ADDENDUM

Completion of this page of the request packet is optional for the provider and is not required for the preauthorization process at APS. The items listed on this page, however, may be required documentation for SURS reviews, CARF certification and/or JCAHO certification. Please do not submit this form to APS as part of the request packet unless instructed to do so on a specific request by an APS review coordinator.

COMMUNITY INTEGRATION: _____

_____

_____

CAREGIVER RESOURCES (for clients under the age of 21): _____

_____

_____

CLIENT'S STRENGTHS/ABILITIES (in client's own words): _____

_____

CLIENT'S LIABILITIES/NEEDS (in client's own words): _____

_____

THEORETICAL APPROACH BEING UTILIZED WITH INDIVIDUAL PSYCHOTHERAPY:

_____

CLIENT'S PREFERENCES:

_____

COLLABORATION WITH SCHOOL SYSTEM (school age children only): _____

_____

REFERRALS TO OTHER COMMUNITY SERVICES: _____

_____

DISCHARGE PLAN:

a. CRITERIA (client-specific behaviors)	b. EST. DATE DISCHARGED	c. AFTERCARE PLAN
_____	_____	_____
_____		_____
_____		_____

Persons involved in development: _____

Collaborative Referrals: _____

_____

_____

Client received resource list information reguarding treatment options if symptoms recur or additional services are needed:

_____

Staff Responsible for Follow-Up of Referrals:

_____