ALABAMA MEDICAID AGENCY PRIOR REVIEW AND AUTHORIZATION REQUEST

Rehab Option

DMH MI (☐) DMH SA (☐) DYS (☐)

Servicing State Agency NPI # _____

Provider Information:	Recipient Information:
Servicing Provider NPI:	Name:
Name of Provider	Address:
Phone with Area Code	City/State/Zip:
Fax with Area Code	DOB:
Address	Admission to Service Date MM/DD/CCYY:
City/State/Zip	

First Diagnosis _____ Second Diagnosis _____

- ☐ Intake Evaluation (always has modifier attached)
- ☐ Physician/Medical Assessment/Treatment
- ☐ Medication Monitoring
- ☐ Family Counseling
- ☐ Diagnostic Testing
- ☐ Mental Illness Child/Adolescent Day Treatment
- ☐ Program for Assertive Community Treatment (PACT)
- ☐ Assertive Community Treatment (ACT)
- ☐ Child/Adolescent In-Home Intervention Model
- ☐ Treatment Plan Review
- ☐ Pre-hospitalization Screening
- ☐ Individual Counseling
- ☐ Family Support
- ☐ Mental Health Consultation
- ☐ Adult Intensive Day Treatment
- ☐ Crisis Intervention
- ☐ Medication Administration
- ☐ Group Counseling
- ☐ Basic Living Skills
- ☐ Adult Partial Hospitalization Program
- ☐ Adult Rehabilitative Day Program
- ☐ Adult In-Home Intervention Model

- ☐ Initial Request for Extended Units for listed Rehabilitative Services
- ☐ Additional Request for Extended Units for listed Rehabilitative Services

PROCEDURE CODE	SERVICE DESCRIPTION	MODIFIER (Check all that apply)						AMOUNT OF EXTENDED UNITS REQUESTED
		HE	HF	HQ	HA	HD	HH	

Clinical Statement: (Include Prognosis and Rehabilitation Potential) - A current plan of treatment and physician statement/summary documenting the rationale for request, as to the necessity, effectiveness and goals of therapy services and medical necessity to request of extended units for rehabilitative service(s). This is required for each of the Rehabilitative Services areas marked above. This documentation must be attached to this form.

Certification Statement: This is to certify that the requested service(s) is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material face may subject me to civil or criminal liability.

Signature of Requesting Provider/Executive Director/Facility Director _____

Date_____

Request for Additional Units

Rendering State Agency NPI: _____

Recipient Name: _____ DOB: _____

Recipient Medicaid ID: _____

Physician: _____

Admission date: _____ Date of review: _____

Reviewer's name: _____ Additional units requested: _____

Reason(s) for request for additional units (check all that apply):

☐ Active intervention by at least one member of the interdisciplinary treatment team for an unresolved program on the patient's treatment plan

☐ Medication changes, administration of PRN medications, medications in liquid form (for suspected noncompliance)

☐ Episodes of inappropriate behavior requiring intervention

☐ Noncompliance with treatment regimen

☐ Suicidal ideation, threat, gesture or attempt

Additional information to support request: _____

_____

Current medications: _____

_____

Participation in groups and other therapies: _____

_____

Most recent MD note: _____

_____

Progress made: _____

_____

Name of physician: _____ Date: _____

Physician signature: _____