# ALABAMA MEDICAID AGENCY PRIOR REVIEW AND AUTHORIZATION REQUEST

**Rehab Option**
- DMH MI (☐)
- DMH SA (☐)
- DYS (☐)

Servicing State Agency NPI #

<table>
<thead>
<tr>
<th>Provider Information:</th>
<th>Recipient Information:</th>
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<tr>
<td>Servicing Provider NPI:</td>
<td>Name:</td>
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<tr>
<td>Name of Provider</td>
<td>Address:</td>
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<tr>
<td>Phone with Area Code</td>
<td>City/State/Zip:</td>
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<td>Fax with Area Code</td>
<td>DOB:</td>
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<tr>
<td>Address</td>
<td>Admission to Service Date MM/DD/CCYY:</td>
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<tr>
<td>City/State/Zip</td>
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First Diagnosis __________ Second Diagnosis __________

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

- [ ] Initial Request for Extended Units for listed Rehabilitative Services
- [ ] Additional Request for Extended Units for listed Rehabilitative Services

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>SERVICE DESCRIPTION</th>
<th>MODIFIER (Check all that apply)</th>
<th>AMOUNT OF EXTENDED UNITS REQUESTED</th>
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<td>HE HF HQ HA HD HH</td>
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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______________

Updated 11/6/17
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: ________________________________