|  |  |
| --- | --- |
| 1) Date of Request:   /  /      | 2) [ ]  Initial Review [ ]  Recertification [ ]  Retro Authorization [ ]  Change  |
| **3) Service Type:****[ ]  PRTF**     | **2) Start Date requested:** **/  /** | **3) Expected Discharge Date:****/****/** |
|   |   | **4) DOB** (mm/dd/yyyy)**:**  //     |
|  | **Requesting retroactive authorization:** **[ ]  Yes** **[ ]  No** |  |
| **5) Member Last Name:**  | **6) Member First Name:**  | **7) Member Medicaid ID #:**  |
|        |        |        |
| **8) Gender: [ ]** Male [ ]  Female | **9) Referring Provider Name/NPI #:**        | **10a.) Servicing Provider Name/ NPI #:**       | **10b.) Servicing Provider Address/ Zip Code:**  |
| **11) Provider Contact Person:**       | **12) Provider Phone #:** | **13) Provider Fax #:** |
|        |        |
| **14) DSM IV:** **Axis I** **Axis II****Axis III****Axis IV** **Axis V (GAF) Current:       Highest Level in Past Year:**

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| **Member Last Name:**       | **Member First Name:**       | **Member Medical ID #:**       |
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**17) INITIAL REVIEW****a. Initial Plan of Care (IPOC), with all the required elements to include Individual Therapy 3 out of every 7 days; 21 treatment Interventions every 7 days; Family Therapy, as applicable, completed, signed and dated as required? [ ]  Yes [ ]  No**  **Date of MD signature on completed IPOC:**      **b. Alternative placements tried or explored in the past year? [ ]  Yes [ ]  No** **Name of Placement(s) Dates Successful?****/  /    \_\_\_\_[ ]  Yes [ ]  No\_\_\_\_\_****/  /    \_\_\_\_[ ]  Yes [ ]  No\_\_\_\_\_****/  /    \_\_\_\_[ ]  Yes [ ]  No\_\_\_\_\_****/  /    \_\_\_\_[ ]  Yes [ ]  No\_\_\_\_\_****If placement(s) not successful, please explain:**      **c. Identify the Discharge Plan:**      **18) For CSA:**     **a. CON signed and dated by the physician and 3 members of the FAPT? [ ]  Yes [ ]  No** **Date of CON:**

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| **Member Last Name:**       | **Member First Name:**       | **Member Medical ID #:**       |
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**b**. **CANS completed? [ ]  Yes [ ]  No** **Date of CANS**     **c. Start date of the Reimbursement Rate Certification:**      **Document the Rate as listed on the Reimbursement Rate Certification: ­­­­**     **For Non-CSA:****d. Pre-Admission Screening Report (DMH224) or CON completed, signed and dated by physician and pre-screener? [ ]  Yes [ ]  No** **Date of Pre-Admission Screening Report or CON signatures:**      **e. For Non-CSA Reviews Only:** **[ ]  Adoption Subsidy Case** **Education Payment Source**  **[ ]  Scholarship (no charge)** **[ ]  Parents** **[ ]  Other:**

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| **Member Last Name:**       | **Member First Name:**       | **Member Medical ID #:**       |
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**19) Severity of Illness: Current symptoms and behaviors:** For the initial review, provide a narrative of the behaviors exhibited by the member within the last 7 days that warrant the requested level of care. Identify frequency, intensity and duration of behavior. Identify the member’s current functioning to include the support system, risk behaviors, social functioning, medications or changes to medications, and ADLs.

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| **Member Last Name:**       | **Member First Name:**       | **Member Medical ID #:**       |
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**20. Concurrent Review****a. Document the Rate as listed on the Reimbursement Rate Certification: ­­­­**      **(For CSA cases only)** **Start date of new rate if applicable:**      **b. CIPOC updated every 30 days with required dated signatures? [ ]  Yes [ ]  No** **Date of most current CIPOC Update:**      **c. Was the CANS completed and current within 90 days? [ ]  Yes [ ]  No**  **Date of CANS:**      **21.** **Number of Overnight Passes since the last review period:**   **a. Successful/Unsuccessful?** **[ ]  Yes [ ]  No****22. Individual Therapy occurring 3 out of every 7 days? [ ]  Yes [ ]  No****23. Twenty-one Treatment Interventions provided every week? [ ]  Yes [ ]  No****24. Identify the Discharge Placement:**      **25. Identify the Orders for Family Therapy:**      **a. Is Family Therapy occurring as ordered?** **[ ]  Yes [ ]  No****b. If Family Therapy is not occurring, please explain:**       |

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| **15)** 1. **(Recertification Only) :**

**Initial Plan of Care (IPOC) with all the required elements to include Individual Therapy 3 out of every 7 days; 21 treatment interventions every 7 days: Family Therapy, as applicable, completed, signed and dated as required?** **[ ]  Yes** **[ ]  No**   **Date of MD signature on completed IPOC:** **/  /**  **b) Alternative placements tried or explored in the past year? [ ]  Yes [ ]  No** **Name of Placement(s) Dates Successful?**      **/  /** **[ ]  Yes [ ]  No**      **/  /     [ ]  Yes [ ]  No**      **/  /     [ ]  Yes [ ]  No**      **/  /     [ ]  Yes [ ]  No** **If placement(s) not successful, please explain:**       **c) Identify the Discharge Plan:**      **16) CON signed and dated by the physician and minimum of 2 members of the Independent Review Team/Non-Facility based / Interdisciplinary** **Team/Facility**? **[ ]  Yes [ ]  No**  **Date of CON:   /  /**  |

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|  **Rater Name/Title:**       | **Bold –** Indicates independent criteria requires automatic admission to a higher level of care regardless of combined score. A score of 4 results in placement at level 5 and a score of 5 results in placement at level 6. **\*\*** Independent criteria may be waived if sum of IV-A and IV-B scores equal 2. |
| **LEVEL OF CARE**  | **SCORE** |  **COMMENTS**  |
| **Rating** | **Criteria** |
| **I.** **RISK of HARM** |       |       |       |
| **II.** **Functional Status \*\*** |       |       |  |
| **III.** **Co-Morbidity\*\*** |       |       |       |
| IV-A.  Recovery Environment Level of Stress |       |       |       |
|  IV-B.  Recovery Environment Level of Support |       |       |       |
|  V.  Resiliency and Treatment History |       |       |       |
|
| VI-A. Acceptance and Engagement Child/Adolescent  |       |       |       |
| VI-B.Acceptance and Engagement Parent/Primary Caretaker |       |       |       |
| **COMPOSITE SCORE**       | **LEVEL of CARE**       | **Date of Calocus:   /  /** |

**INSTRUCTIONS FOR INPATIENT ELECTRONIC FAX FORM**

[**http://scdhhs.kepro.com**](http://scdhhs.kepro.com)

This FAX submission form is required for faxed Inpatient Initial Certification, Recertification, and Retrospective Reviews. When submitting the fax, please be certain that the cover sheet has a confidentiality notice included.

Please be certain that all information blocks contain the requested information. Incomplete forms may result in the case being denied or returned via FAX for additional information. Only information provided on KePROforms can be entered.

If KePRO determines that your request meets appropriate coverage criteria guidelines. Final approval is contingent upon passing remaining Member and Provider eligibility/enrollment edits. The Prior Authorization (PA AUTH) number provided by KePRO will be provided to you via Fax back process and will be available to providers registered on the web-based program Atrezzo Connect ([http://scdhhs.kepro.com](http://dmas.kepro.com)). **This excludes weekends and holidays.**

1. **Date of Request:** The date you are submitting the Prior Authorization request.
2. **Request type:** Place a √ or **X** in the appropriate box.
	* **Initial:** Use for all newrequests. Resubmitting a request after receiving a reject would be an initial request also.
	* **Retrospective Review:** A request for Retrospective review due to retroactive eligibility.
	* **Change**: If additional units are requested for the same dates of service, enter the total number of units needed and not only the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders. The provider may not submit a “change” request for any item that has been denied or is pended.
3. **Expected Discharge (D/C) Date and Discharge placement:**
* Enter the expected discharge date on the line provided.
* Enter the expected discharge placement on the line provided (i.e. permanent foster care, return home, adoption, etc.)
1. **Date of Birth**:
* Enter the Member’s date of birth in the MM / DD / YYYY format (for example, 02/25/2008)
1. **Member Last Name:**
* Enter the Member’s last name exactly as it appears on the Medicaid card.
1. **Member First Name:**
* Enter the Member’s first name exactly as it appears on the Medicaid card.
1. **Member Medicaid ID Number:**
* It is the provider’s responsibility to ensure the Member’s Medicaid number is valid. This should contain 12 numbers.
1. **Gender:**
* Please place a **√** or **X** to indicate the gender of the Member.
1. **Provider Name:**
* Enter the referring provider name
1. **Servicing Provider Name/NPI # :**
* a. Enter the service provider’s name and NPI # .
* b**. 9 digit Zip Code (Mandatory):** Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI/API number being submitted.
1. **Provider Contact Person:**
* Enter the primary contact for the requesting/service provider.
1. **Provider Phone Number:**
* Enter the phone number of the requesting/service provider.
1. **Provider Fax Number:**
* Enter the fax number of the requesting/service provider.
1. **DSM-IV Diagnoses:**
* Enter the complete DSM-IV diagnosis
1. PA Review
* a. Please place a √ or X in the box to indicate the required elements to include Individual Therapy 3 out of every 7 days; 21 treatment Interventions every 7 days; Family Therapy, as applicable, completed, signed and dated as required
	+ Provide the date of Medical Doctor’s signature on IPOC
* b. Please place a √ or X in the box to indicate if alternative placements tried or explored in the past year
	+ If applicable provide name of placement and dates in placement.
	+ Explain unsuccessful placements.
* c. Provide the name of placement expected upon discharge.
1. Please confirm CON signed and dated by the physician and minimum of 2 members of the Independent Review Team/Non-Facility based / Interdisciplinary Team/Facility
2. Provide Calocus Score Sheet results. Include Date completed, composite score and Level of Care.