PSYCHIATRIC & SUBSTANCE ABUSE/ADDICTIVE DISORDERS: Residential Level of Care

For authorization, please complete this form, include patient chart notes to document information and FAX to the PEHP Prior Authorization Department at (801) 366-7449 or mail to: 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization or benefit questions, please call PEHP Customer Service at (801) 366-7555 or toll free at (800) 753-7490. ***Please verify the employer group's residential treatment benefits.***

Section I: PATIENT INFORMATION

Patient Name (Last, First MI):	DOB:	Age:	PEHP ID #:

Patient's Home Address:	Parent/Guardian Name *(if patient under 18)*:
Patient or Parent/Guardian Phone *(if patient under 18)*: **Primary Phone: ( )** **Alternate Phone: ( )**	**Patient or Parent/Guardian Email *(if patient under 18)*:**

Section II: PROVIDER INFORMATION

Date Requested:	Facility Name:	Facility Address:

Facility NPI #:	Facility Tax ID #:	Facility Contact Person:	Phone:	Facsimile:	Email:
			( )	( )	

Section III: PRE-AUTHORIZATION REQUEST

Nature of Request: *Please check.*	Requested Admit Date:	Type of Commitment:
☐ Initial Admit ☐ Concurrent Review/Additional Days ☐ Retro Auth		☐ Involuntary ☐ Voluntary

Number of Initial Days Requested:	Number of Additional Days Requested:	Estimated Length of Stay:	Target Discharge Date:

Admission Source/Type: ***Please check/specify.***

☐ Direct Admit
☐ Emergency Room
☐ Step Down from Inpatient
☐ Step Up from Day Treatment
☐ Step Up from Intensive Outpatient
☐ Step Up from Outpatient Therapy
☐ Transfer from Outside Hospital (***Name:*** _____)
☐ Other: _____

Type of Residential Treatment Services Requested: *Please check.*	Primary Diagnosis/ICD-10 Code:	Secondary Diagnosis/ICD-10 Code:
☐ Psychiatric (Revenue Code 1001) ☐ Substance Abuse (Revenue Code 1002)		

Previous Mental Health/Substance Abuse Treatment: ***Please check/specify all that apply.***

☐ Acute Inpatient Medical Detox
☐ Day Treatment/Partial Hospitalization
☐ ECT/Electroconvulsive Therapy
☐ Inpatient Mental Health
☐ Intensive Outpatient Therapy
☐ Ketamine Infusions
☐ Outpatient Therapy
☐ Pharmacologic Agents
☐ Residential
☐ Sub-Acute/Social Detox
☐ TMS/Transcranial Magnetic Stimulation
☐ Other: _____

Presenting/Current Symptoms: ***Please check/specify all that apply.***

☐ Anger (Outbursts/Aggressiveness)
☐ Anxiety
☐ Appetite issues
☐ Attention issues
☐ Auditory hallucinations
☐ Cognitive deficits
☐ History of homicidal actions
☐ History of suicidal actions
☐ Homicidal attempt
☐ Homicidal ideations
☐ Homicidal intent/plan
☐ Impulsivity
☐ Learning/school/work issues
☐ Legal issues
☐ Mood lability
☐ Panic Attacks
☐ Participating in risky behavior
☐ Poor motivation
☐ Problems with performing ADL's
☐ Problems with treatment compliance
☐ Psychosis
☐ Significant weight gain/loss
☐ Sleep disturbances
☐ Social support problems
☐ Somatic complaints
☐ Substance abuse
☐ Suicidal attempt
☐ Suicidal ideation
☐ Suicidal intent/plan
☐ Visual hallucinations
☐ Other _____

(Please check service being requested.) QUESTION	YES	NO	COMMENTS/NOTES
A. ☐ Adult, Child, or Adolescent Psychiatric Residential Treatment Admission:			
1. Is the patient having symptoms and behaviors, which represent a deterioration from the patient's usual status?	☐	☐	
2. Is the patient having self-injurious or risk-taking behaviors that risk serious harm?	☐	☐	
3. Can the patient be managed outside of a 24-hour structured setting or other appropriate outpatient setting?	☐	☐	
4. Is the patient's social environment characterized by temporary stressors or limitations that would undermine treatment that could potentially be improved with treatment while the patient is in a residential facility?	☐	☐	
5. Is there a reasonable expectation that the illness, condition, or level of functioning will be stabilized and improved and that a short term subacute residential treatment service will have a likely benefit on the behaviors/symptoms that required this level of care and that the patient will be able to return to outpatient treatment?	☐	☐	
6. Is the patient's clinical condition of such severity that an evaluation by a physician or other provider with prescriptive authority is indicated at admission and weekly thereafter?	☐	☐	

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Name (Last, First MI):	DOB:	Age:	PEHP ID #:

(Please check service being requested.) QUESTION (*cont'd*)	YES	NO	COMMENTS/NOTES
B. ☐ **Substance Abuse and Addictive Related Residential Treatment Admission:**			
1. Does the patient have no withdrawal symptoms or if so, can the patient be safely managed at this level of intensity care?	☐	☐	
2. Does the patient have an active medical condition requiring treatment that can be monitored and/or managed at this level?	☐	☐	
3. Does the patient have emotional, behavioral, or cognitive problems or functional limitations in the context of the home environment that are severe enough that the member is not likely to maintain stability or abstinence without 24-hour care?	☐	☐	
4. Has the patient demonstrated an inability to achieve sustained sobriety at a less restrictive level of care?	☐	☐	
C. ☐ **Adult Psychiatric Residential Treatment Continued Stay:**			
1. Is the patient being evaluated by a physician or other provider with prescriptive authority every week?	☐	☐	
2. Has there been progress with the patient's psychiatric symptoms and behaviors?	☐	☐	
2. a. If there has been limited or no progress is the treatment plan being re-evaluated and changed with goals that are achievable?	☐	☐	
3. Is the patient cooperative with treatment plan and meeting treatment plan goals?	☐	☐	
4. Is continued stay primarily for providing custodial care defined as non-health related services such as activities of daily living (i.e., bathing, feeding, dressing) or health related services provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, or services that do not require continued administration by trained medical personnel to be delivered safely and effectively?	☐	☐	
5. Is there weekly family/significant other therapy unless clinically contraindicated?	☐	☐	
D. ☐ **Children and Adolescent Psychiatric Residential Treatment Continued Stay:**			
1. Is the patient and family involved to the best of their ability in the treatment and discharge planning process?	☐	☐	
2. Is the provided treatment leading to measurable clinical improvements in acute symptoms and a progression towards discharge from the present level of care, but the patient is not sufficiently stabilized so that he/she/they can be safely and effectively treated at a less restrictive level of care?	☐	☐	
2. a. If no, is there ongoing assessment and modifications to the treatment plan if clinically indicated?	☐	☐	
3. If the current treatment plan is not leading to measurable clinical improvements in acute symptoms and a progression	☐	☐	
4. Has the patient developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment?	☐	☐	
5. Is continued stay primarily for providing a safe and structured environment?	☐	☐	
6. Is continued stay primarily being requested due to a lack of external support?	☐	☐	
7. Is there at least weekly in-person/face-to-face family therapy unless contraindicated?	☐	☐	
E. ☐ **Substance Abuse and Addictive Related Residential Treatment Continued Stay:**			
1. Has there been progress in the patient's withdrawal symptoms and behaviors?	☐	☐	
1. a. If there is no progress in withdrawal symptoms and/or behaviors is the treatment plan being re-evaluated and changed with goals that are still achievable?	☐	☐	
2. Is the patient cooperative with treatment plan to meet goals of therapy?	☐	☐	
3. Has the patient developed new symptoms and/or behaviors that require residential intensity of service for safe and effective treatment?	☐	☐	
4. Is the patient and family involved to the best of their ability in the treatment and discharge planning process?	☐	☐	
5. Is continued stay primarily for providing a safe and structured environment?	☐	☐	
6. Is continued stay primarily being requested due to a lack of external support?	☐	☐	

Aftercare Planning Notes:

Additional Comments:

Please fax completed form, CRISIS EVALUATION (if applicable), and medical records to 801-366-7449.