AmeriHealth Caritas Louisiana

# Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

Fax completed form to the AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (BH UM) department at **1-855-301-5356**. If you have any questions, please contact BH UM at **1-855-285-7466**.

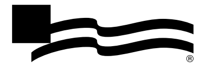
All PRTF authorizations are based on medical necessity of services. The below supporting clinical documentation must be submitted with the PRTF Authorization request form. **All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide a medical necessity determination to BH UM. Failure to submit all clinical documentation may result in a processing delay.**

1. The request must include the below supporting documentation to be reviewed for medical necessity:
   a. Most recent psychosocial and/or diagnostic assessment by an licensed mental health practitioner (LMHP) within the last six months.
   b. Court order for placement and custodial orders, if applicable.
   c. Most recent IEP/504 plan, if applicable.
   d. Psychological and/or neuropsychological testing, if applicable.
2. Upon receiving all clinical information, BH UM will schedule a telephonic review to determine medical necessity. The telephonic review must include the LMHP who has completed a face-to-face assessment/session with the member.

| Referral information | | |
|---|---|---|
| Date of referral: | Referral contact: | |
| Referring facility/agency: | Phone: | Fax: |

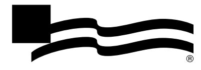
| Demographic information (please print) | | | |
|---|---|---|---|
| Child's name: | Date of birth: | Age: | Medicaid ID: |
| Ethnicity: | Language: | Diagnosis: | |
| Home address and phone number: | | | |
| City: | State: | ZIP: | |
| Custody (Department of Children and Family Services [DCFS], parents, other family, juvenile court, other agency): | | | |
| Name of custodian: | Relationship: | Phone: | |

| LMHP recommending PRTF level of care | |
|---|---|
| Provider name: | Phone: |
| Contact person: | Phone: |
| NPI or tax ID number: | Fax: |
| Date the LMHP completed a face-to-face assessment or session with the member? | |
| What is the member's current status or placement? | |



| Reason for referral | | |
|---|---|---|
| Current mental health and/or substance use disorder symptoms (frequency, dates, or consequences that led to a referral for PRTF): | | |
| What are the contributing factors to the main clinical need or problem? | | |
| What are the goals for the PRTF and recommended interventions for the contributing factors indicated above? | | |
| Current living situation: | | |
| Family history (psychiatric, substance use, domestic violence, family stressors, etc.): | | |
| Family's role in treatment: | | |
| DCFS, JOC, Legal FINS, or OJJ involvement? ☐ Yes ☐ No<br>If yes, indicate type: | Contact name: | Phone number: |
| Child's current grade level: | Current school: | Special education classification?<br>☐ Yes ☐ No |
| Academic, behavioral, or social functioning in school (note any suspensions or expulsions): | | |

| All medication | Dose | Schedule | Prescribing M.D. | Target symptoms |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |



| Treatment history | Yes/no/unknown | Provider | Service date |
|---|---|---|---|
| Psychiatric hospitalization | ☐ Yes ☐ No ☐ Unknown | | |
| Substance use treatment | ☐ Yes ☐ No ☐ Unknown | | |
| Mental Health Reporting System (MHRS) | ☐ Yes ☐ No ☐ Unknown | | |
| Coordinated System of Care (CSOC) | ☐ Yes ☐ No ☐ Unknown | | |
| Psychiatric Residential Treatment Facility (PRTF) | ☐ Yes ☐ No ☐ Unknown | | |
| Therapeutic group home | ☐ Yes ☐ No ☐ Unknown | | |
| Crisis stabilization | ☐ Yes ☐ No ☐ Unknown | | |
| Therapeutic foster care | ☐ Yes ☐ No ☐ Unknown | | |
| Psychological and/or neuropsychological testing | ☐ Yes ☐ No ☐ Unknown | | |
| Medical treatments/concerns | ☐ Yes ☐ No ☐ Unknown | | |

A medical necessity determination will be made after a review of all required clinical information and a telephonic review. Once a medical necessity determination is made, the referral source and/or PRTF — if one has accepted the member — will be notified within 48 hours of the determination. If the PRTF admission is determined medically necessary and a PRTF placement has not been solidified, this will be required of the referral source.

AmeriHealth Caritas™
Louisiana