## South Carolina School District - Name of School Treatment Review & Authorization Request

☐ Initial Request- PA Form/ Clinical Assessment/IPOC							☐ Re-Authorization Request/PA Form/90 day Progress Summary						
Admission Date: Start Date of Services:							Date of Request:						
					Managed Ca	are Orga	nizati	on					
Phone: (866) 341-8765 Phone: (88 Fax: (888) 796-5521			ue Choice (66) 902-1689- opt 2 (77) 664-1499	olina 🔲 🗖 Ak		□Ab	<b>solute Tota</b> 1866-694-		☐ Wellcare Crisis Fax: (888) 588-9842 Fax: (888) 343-5364				
			S	School District	Contact Info	rmation	Provi	ider(s)	Informati	on			
Sch	School District Name: Address:					Medicaid Provider #:				NPI #:			
Bill	ling Persor	n Contact Nam	e:							Phone #: Fax #:			
				LP	HA Referral C	Contact I	Inforn	nation			rax #.		
LPi	LPHA (Contact):										one#:		
					Child's	Informa	tion						
Chi	Child's Name: Name on MCO/Insurance									Med	1edicaid#		
Add	Address: Parent/Guardian Nat					<u> </u>				Phone #:			
Other Insurance – Name: Member Number:													
					Curren	t Diagno	ses						
De:	scription: -Occurring		Yes [	□ No □ Def						<b>-</b>			
		medication or		n name, dosago if applicable.	e, trequency a	ana pres	cribei	r): 🗀	None L	□ Yes			
		Treatment	Requ	est: please o	check service	es bei	ng re	quest	ed for tl	he RE	BHS program:		
			-	Services	ervices		reque	ency	cy Encounters/ Number of Units		Start Date of Services	Target End Date	
	96101	Psychological Testing and Evaluation											
	90832	Individual Psychotherapy - 30 min											
	90834	Individual Psychotherapy - 45 or more											
	90837	Individual Psychotherapy - 60 mins or more									-		
	90846 90847	Family Psychotherapy without Patient Family Psychotherapy with Patient											
$\vdash$	90847												
	90853 Group Psychotherapy  Community Support Services  H2014 Behavioral Modification												
	H2017			bilitation Serv	rices – Individ	ual							

S9482 Family Support										
All MCOs require a prior authorization for con	tinued services and Psychological	ogical Testing and Evaluation.								
All services must meet medical necessity criteria to justify services. Risk Factors may interfere with the ability to function in daily living,										
personal relationships, school and recreational settings that assist in determining medical necessity for services or the need for an										
additional assessment.										
To Re-Authorize Community Support Services, the child must meet all the following medical necessity criteria.										
☐ The desired outcome(s) of services has not been met.										
☐The family /caregiver/guardian is engaged in the treatment process.										
☐ The child is at risk for out-of-home-placement.										
Justification for Authorization: (Be specific about descri	<u> </u>									
Date of onset of Symptoms:	Duration of Symptoms:									
Describe symptoms or issues:										
List previous Objective(s)	Outcome /Progress / Ach	ievement of the Objective(s)								
List <b>new objectives</b> to be prior authorized. List expected outcomes to improve the child behavior: (Briefly describe how client										
is likely to benefit from the services requested or purpose of the treatment in relation to expected outcomes)										
List requested Objective (s)		Purpose of the treatment and expected outcome(s)								
Provious and/or current Treatment history and Outcom	ne. □ None □ Ves See Initial	Clinical Assessment								
Previous and/or current Treatment history and Outcome: ☐ None ☐ Yes. See Initial Clinical Assessment  Discharge/Transition Plan: (90 Day progress summary) Inpatient Admission in the last 90 days: ☐ None ☐ Yes										
Significant changes in member's life since last assessment-  Date of Last Assessment:										
None. This is an initial request for services □ No significant changes										
☐ Changes noted as follows:										
Comments:										
Comments.										
LPHA Print Name:	Signature:	Date:								