Healthy Blue

Medicaid Managed Care

Behavioral Health Psychiatric Residential Treatment Facilities Initial Review Form

Please submit this form using our preferred method via www.Availity.com or you can choose to fax to to **1-844-432-6027** before admission.

Today's date:		
Contact information		
Member name:	Member ID or reference number:	Member date of birth:
Member address:	Member phone number:	
For child/adolescent, name of parent/guardian:	Primary spoken language:	
Facility/provider submitting clinical review:	Requested psychiatric residential treatment facility (PRTF), if applicable:	
Requested PRTF admit date:	Member's current location:	
Can member return to current location if applicable?		
For members with a home- and community-based services waiver, please include support/service coordinator/targeted case manager information.		
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) support coordinator name:	EPSDT support coordinator phone:	EPSDT support coordinator fax:
Clinician or doctor who can provide PRTF precertification review (if needed):	Clinician or doctor's phone number:	
Person completing form:	Phone number of person completing form:	
Diagnosis (**psychiatric, chemical dependency and medical**)		

BLAPEC-1987-20 August 2020

Precipitant to admission (Be specific. Why is the PRTF level of care needed?)
Clearly document behaviors occurring in the previous three months.
Barriers to treatment progress (if admitted)

Current legal issues
Is member in a juvenile detention center? Has member had an adjudication hearing? If so, what is the date? Is member in jail?
Substance use or dependence (current urinary analysis/lab results)

Previous treatment (Include provider name, facility name, medications, specific treatment/levels of care and adherence.) **Please attach current psychological.**
Please be specific: inpatient, rehab, partial hospitalization program, inpatient/outpatient program, inpatient family intervention, community support individual, intensive community supports, etc. What are the dates of service and provider names?
Current treatment plan
Standing medications:
As-needed (PRN) medications administered (not ordered):
Other treatment and/or interventions planned (including when family therapy is planned):

Support system
Include coordination activities with case managers, family, community agencies, etc. If case is open with another agency, name the agency, phone number and case number.
Social history (Include school, family and community, behavioral issues, developmental issues, individualized education program.)

Initial discharge plan (List name and phone number of discharge planner. List names of providers, addresses and phone numbers.)	
Days requested for this review:	
Expected length of stay from today:	
Submitted by:	**Phone number:**