

**South Carolina School District – [Enter School Name]
Treatment Review & Prior Authorization (PA) Request**

☐ Initial Request - PA Form/Clinical Assessment/Most Recent IPOC/Most Recent Progress Summary/Three Most Recent Clinical Service Notes

☐ Re-Authorization Request - PA Form/Clinical Assessment/Most Recent IPOC/Most Recent Progress Summary/Three Most Recent Clinical Service Notes

Admission Date: _____

Start Date of Services: _____

Date of Request: _____

Managed Care Organization						
<input type="checkbox"/> Select Health Phone: (866) 341-8765 Fax: (888) 796-5521	<input type="checkbox"/> Healthy Blue Phone: (866) 902-1689-opt 3 Fax: (877) 664-1499	<input type="checkbox"/> Molina Phone: 855-237-6178 Fax: (866) 423-3889	<input type="checkbox"/> Absolute Total Care Phone: (866) 433-6041 Fax: (866) 694-3649	<input type="checkbox"/> Humana Healthy Horizons Phone: (866) 432-0001 Fax: (833) 441-0950		
School District/Provider(s) Contact Information						
School District Name:	Address:	Medicaid Provider #:	NPI #:			
Billing Person Contact Name:			Phone #:			
			Fax #:			
LPHA Referral Contact Information						
LPHA (Contact):			Phone #:			
Child's Information						
Child's Name:	Name on MCO/Insurance Card:	Date of Birth:	Medicaid #:			
Address:	Parent/Guardian Name:			Phone #:		
Other Insurance – Name:		Member Number:				
Current Diagnoses						
ICD-10 or DSM-5 or Z code:						
Description:						
Co-Occurring Disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Define:						
Current Medications (medication name, dosage, frequency and prescriber): <input type="checkbox"/> None <input type="checkbox"/> Yes						
List or attach medication orders, if applicable.						
Treatment Request: Please check services being requested for the RBHS program.						
		Services	Frequency	Encounters/ Number of Units	Start Date of Services	Target End Date of Services
	96130	Psychological Testing and Evaluation - 1st Hour				
	96131	Psychological Testing and Evaluation – Next Hour				
	96136	Psychological or Neuropsychological Test Administration and Scoring				
	96137	Psychological or Neuropsychological Test Administration and Scoring				
	90832	Individual Psychotherapy - 30 min				
	90834	Individual Psychotherapy - 45 or more				
	90837	Individual Psychotherapy - 60 mins or more				
	90846	Family Psychotherapy without Patient				
	90847	Family Psychotherapy with Patient				

90853	Group Psychotherapy				
Community Support Services (Districts enrolled before 07/01/2022)					
H2014	Behavioral Modification - 15 mins				
H2017	Psychosocial Rehabilitation Services – 15 mins <input type="checkbox"/> Individual <input type="checkbox"/> Group				
S9482	Family Support				
All MCOs require a prior authorization for continued services and Psychological 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.					
<input type="checkbox"/> The desired outcome(s) of services has not been met.					
<input type="checkbox"/> The family /caregiver/guardian is engaged in the treatment process.					
<input type="checkbox"/> The child is at risk for out-of-home-placement.					
Justification for Authorization: (Identify and describe specific symptoms). Complete all Sections Below.					
Date of onset of Symptoms:		Duration of Symptoms:			
Describe symptoms or issues:					
List previous Objective(s)		Outcome /Progress / Achievement of the Objective(s)			
List new objectives 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)			
Previous and/or current Treatment History and Outcome: <input type="checkbox"/> None. <input type="checkbox"/> Yes. See initial clinical assessment.					
Discharge/Transition Plan: (Progress summary)					
Inpatient Admission in the last 90 days: <input type="checkbox"/> None <input type="checkbox"/> Yes					
Date of Last Assessment:					
Significant changes in member's life since last assessment?					
<input type="checkbox"/> This is an initial request for services.					
<input type="checkbox"/> No significant changes.					
<input type="checkbox"/> Yes. Changes noted as follows:					
Comments:					
LPHA Print Name:		Signature:		Date:	