Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Inpatient Mental Health

Upload this request through the Provider Web Portal. For questions regarding this form, call: (800) 525-2395

REQUEST DATE: _____/_____/_____

REQUEST TYPE: ☐ Initial Review

☐ Retrospective (For retrospective requests, please indicate the date of eligibility decision, the start date of services, the number of days being requested at the Acute level of care and, *if applicable*, the number of days being requested at the Skilled level of care.)

Date of Eligibility Decision: _____ Start date: _____

Retrospective Acute LOC days: _____ Retrospective Skilled LOC days: _____

NOTES:

I. RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient Medicaid ID:		DOB:
Address:		
City:	State:	Zip Code:
Phone:	Date recipient went into DHS Custody:	

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Describe recipient's current living environment, or, if already admitted, describe living environment prior to admission.

☐ Alone ☐ Foster Home ☐ Group Home ☐ With Parent ☐ Med/Surg Hospital ☐ With Non-Relative

☐ Psychiatric ☐ With Relative ☐ PRTF ☐ With Spouse ☐ Unknown ☐ Other:

II. RESPONSIBLE PARTY INFORMATION *(Complete this section when the responsible party is not the recipient.)*

Responsible Party Name:		
Relationship to Recipient: ☐ Court ☐ Government Agency ☐ Parents ☐ Relative ☐ Other:		
Address:		
City:	State:	Zip Code:
County:	Phone:	

III.ADMITTING FACILITY INFORMATION

Name:		NPI:
Address:		
City:	State:	Zip Code:
Telephone Number:	Fax Number:	

IV. TREATMENT HISTORY

Has the recipient had prior inpatient treatment? ☐ No ☐ Yes *(If yes, enter facilities and service dates below.)*

Inpatient Mental Health

Facility Name	Length of Stay	Facility Name	Length of Stay
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

Has the recipient had prior outpatient treatment? ☐ No ☐ Yes *(If yes, complete the following lines.)*

Provider Name	Dates of Service	Frequency of Service	Outcome of Service
1.			
2.			
3.			
4.			

Other Placements *(Foster Care, Group Home, Shelter, Detention, Training School, Boot Camp, etc.)*

Facility Name	Length of Stay	Facility Name	Length of Stay
1.	to	4.	to
2.	to	5.	to
3.	to	6.	to

V. ICD-10 DIAGNOSIS

Primary Code:	Disorder:
Secondary Code:	Disorder:
Tertiary Code:	Disorder:

VI. SYMPTOMS AND MEDICATIONS

Current symptoms requiring inpatient care: *(include clinical rationale for number of days being requested for review and evaluation of risk*)

What is the recipient's CASII/LOCUS assessment level? If lower than 6, please provide details about why this level of care is still being requested.

Inpatient Mental Health

Chronic behaviors:

SAPTA Certified: ☐ **Yes** ☐ **No**

If Yes, and if you are requesting one of the following revenue codes (0116, 0126, 0136, 0146 or 0156) for a recipient 21 to 64 years of age, please submit a copy of your Substance Abuse Prevention and Treatment Agency (SAPTA) Certification as an additional attachment.

Does the recipient have any drug/alcohol issues? ☐ Yes ☐ No *(If Yes, complete the next two rows.)*

Substances used:

Frequency/Amount of use:

Has the recipient received drug/alcohol treatment? ☐ Yes ☐ No *(If Yes, complete the next two rows.)*

Where was treatment received?

When was treatment received?

Blood Alcohol content results:_____

Toxicology Screening results:_____

Urine Drug Screen results: _____

Describe any drug/alcohol withdrawal symptoms:

Use the lines below to list the recipient's current medications.

Drug Name	Dosage	Purpose	Dates Used
1.			to
2.			to
3.			to
4.			to

Precautions:

Frequency of checks:

Inpatient Mental Health

If applicable, list the most recent lab levels for the above medications:

VII. REQUESTED TREATMENT

Requested Treatment: ☐ SA Rehabilitation ☐ Detoxification ☐ Inpatient Psychiatric		
Are you requesting EPSDT referral/services? ☐ Yes ☐ No		
Admission Status: ☐ Voluntary ☐ Emergency ☐ Court-Ordered		
Admission Date:	Number of days requested:	
Attending Physician Name:		Phone:
Inpatient services that will be provided to this recipient:		
Discharge Plan and Discharge Criteria:		

Inpatient Mental Health

Certificate of Need

REQUESTED ADMISSION DATE: _____/_____/_____

SERVICE TYPE: ☐ Inpatient Psychiatric ☐ Psychiatric Residential Treatment Facility (PRTF) Initial Request

RECIPIENT INFORMATION

Recipient Name (Last, First, MI):	
Recipient ID:	DOB:

CASE MANAGER INFORMATION

Does the recipient have a case manager? ☐ Yes ☐ No	Case Manager Name:
Mental Health Center:	Phone:
Case Manager Signature:	Date:

ADMITTING FACILITY INFORMATION

Facility Name:	NPI:
Phone:	Fax:

CERTIFICATION STATEMENTS

A physician acting within the scope of practice as defined by State law certifies the following per 42 CFR 441.152:

1. Ambulatory care resources available in the community do not meet the treatment needs of the recipient listed above.
2. Proper treatment of the recipient's psychiatric condition requires inpatient or residential treatment services under the direction of a physician.
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

PHYSICIAN CERTIFICATION *(required)*

Name:	Title:
Signature:	Date:
Additional Notes:	

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.