Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Residential Treatment Center Concurrent Review

Upload this request through the Provider Web Portal. Questions? Call: (800) 525-2395

REQUEST DATE: _____ /_____ /_____

REQUEST TYPE: ☐ Concurrent Review

☐ Retrospective Authorization – Date of Eligibility Decision_____

NOTES:

I. RECIPIENT INFORMATION

Recipient Name:	
Recipient Medicaid ID:	DOB:
Is the recipient in state custody? ☐ Yes ☐ No	

II. CASE MANAGEMENT INFORMATION

Does the recipient have a case manager? ☐ Yes ☐ No	Case Manager Name:
Case Management Organization:	Phone:

III. FACILITY INFORMATION

Facility Name:	NPI:	
Address:		
City:	State:	Zip Code:
Phone:	Fax:	

IV. ICD-10 DIAGNOSIS

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

V. CLINICAL INFORMATION

Date of Admission:	Number of RTC days requested:	Requested Start Date:
Are you requesting EPSDT referral/services? ☐ Yes ☐ No		
Special precautions for this recipient: ☐ Suicide ☐ Aggression ☐ Elopement ☐ Other:		

List of Current Medication(s) (If more space is needed please provide this as an attachment)	**Dosage**	**Start Date**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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Medications Given PRN (As Needed), i.e., medications not scheduled that were given during the review period	**List all dates and times PRN Medication was given** (If PRN medications needed to be given during this review period, please discuss any behaviors leading up to the need for the PRN medication in the related boxes below for justification for continued services, critical incidents, restraints, etc.)
1.	
2.	
3.	
4.	
5.	

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

Describe the recipient's current mental status:

Discuss justification for continued services at this level of care:

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Critical Incidents/Special Procedures (include dates and describe precipitating events):

Describe recipient's participation in groups and activities:

Has the recipient's family demonstrated progress and cooperation toward treatment goals? ☐ Yes ☐ No

Summarize outcome of family therapy sessions. If family is not demonstrating progress and cooperation toward treatment goals, please detail next steps to correct this or describe other discharge plans.

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Describe recipient's current treatment plan and goals:
Recipient's Estimated Date of Discharge:
Describe the discharge plan for this recipient:

VI. PROVIDER INFORMATION

Provider Name:	Phone:
Professional Title:	Fax:
Provider Signature:	**Date:**

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, terms & conditions set forth by the benefit program. The information contained on this form, including attachments, is privileged & confidential & 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 has been received in error, the reader shall notify the sender immediately and shall destroy all information received.