Prior Authorization Request
Nevada Medicaid and Nevada Check Up

Inpatient Mental Health 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:	Age:

II. FACILITY INFORMATION

Facility Name:	NPI:
Address *(include city, state, zip)*:	
Phone:	Fax:

III. ICD-10 DIAGNOSIS

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

IV. CLINICAL INFORMATION

Date of Admission:	Number of days requested:	Requested Start Date:
Service: ☐ Acute ☐ Skilled		
Are you requesting EPSDT referral/services? ☐ Yes ☐ No	This request is for a(n): ☐ Youth ☐ Adult	
Date of physician's initial admission assessment:		
Special precautions for this recipient: ☐ SP ☐ Aggression ☐ Elopement ☐ Other:		
Intervals: ☐ q15 ☐ q30 ☐ q 1 hour ☐ Routine ☐ Other:		

Current Medication(s)	Dosage	Start Date
1.		
2.		
3.		

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

Describe the recipient's current mental status:

Inpatient Mental Health Concurrent Review

Describe recipient's participation in groups and activities:
Describe recipient's current individualized treatment plan and goals (*please update as appropriate*):
Discuss justification for continued services at this level of care (*evaluation of risk and level of acuity to demonstrate medical necessity for number of days being requested for review*):
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.
Recipient's Estimated Date of Discharge:
Describe the discharge plan and discharge criteria for this recipient (*note placement options and efforts to discharge*):

Inpatient Mental Health Concurrent Review

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

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.