

# Fax Transmittal Sheet

Nevada Medicaid and Nevada Check Up – Inpatient Mental Health (FA-12)

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**To:** Hewlett Packard Enterprise

**Fax Number:** (866) 480-9903

**Phone Number:** (800) 525-2395

**From:**

**Fax Number:**

**Phone Number:**

**Date:**

**Number of Pages:**   
(including this cover page)

**Contact Person's Name:**

**Contact Person's Email:**

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**Urgent**

**For Approval**

**Please Comment**

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Comments

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## Inpatient Mental Health

Fax this request to: (866) 480-9903

For questions regarding this form, call: (800) 525-2395

**REQUEST DATE:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**REQUEST TYPE:**  Initial Review  Reconsideration

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: \_\_\_\_\_

### 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  RTC  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.)*

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



### Inpatient Mental Health

Recipient Name (Last, First, MI):	
Frequency of checks:	
<b>VII. REQUESTED TREATMENT</b>	
Requested Treatment: <input type="checkbox"/> SA Rehabilitation <input type="checkbox"/> Detoxification <input type="checkbox"/> Inpatient Psychiatric	
Are you requesting EPSDT referral/services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Admission Status: <input type="checkbox"/> Elective <input type="checkbox"/> Emergency <input type="checkbox"/> 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  Residential Treatment Center (RTC) 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:

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.*