Prior Authorization Request Form
Nevada Medicaid and Nevada Check Up

Residential Treatment Center

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

REQUEST DATE: _____ /_____ /_____

REQUEST TYPE: ☐ Initial Review

☐ Retrospective Authorization – Date of Eligibility Decision_____

NOTES:

I. RECIPIENT INFORMATION

Recipient Name (Last, First, MI):		
Recipient Medicaid ID:		DOB:
Address:		Phone:
City:	State:	Zip Code:
Recipient's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced		
Where does recipient reside? ☐ Group Home ☐ Parents ☐ Relatives ☐ Foster Care ☐ Other:		
Is the recipient currently in state custody? ☐ Yes ☐ No		

II. RESPONSIBLE PARTY INFORMATION

Name:		
Address:		Phone:
City:	State:	Zip Code:
Relationship to recipient: ☐ Parents ☐ Other relative ☐ Government agency ☐ Other:		

III. ADMITTING 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

Admission Status: ☐ Elective ☐ Involuntary ☐ Voluntary ☐ Court Committed ☐ Other:			
Recipient Transferred From:			
Is this request for Healthy Kids (EPSDT) services? ☐ Yes ☐ No			
Special precautions for this recipient: ☐ SP ☐ Aggression ☐ Elopement ☐ Other:			
Intervals: ☐ q15 ☐ q30 ☐ q 1 hour ☐ Routine ☐ Other:			
Recipient's Current Medication(s)	**Dosage**	**Frequency**	**Start Date**
1.			
2.			
3.			
4.			

Residential Treatment Center

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 Level (if done):	Urine Drug Screen (if done):
Describe any drug/alcohol withdrawal symptoms:	
What is the recipient's current mental status?	
Which symptoms/behaviors necessitate residential treatment?	
Is there active involvement by family members and/or pre-admission caregivers? ☐ Yes ☐ No	
Describe the recipient's living environment *(e.g., who lives in the home, relevant history, current support)*:	
Have less restrictive services been documented as insufficient to meet the individual's needs? ☐ Yes ☐ No	
Does the recipient meet SED criteria? ☐ Yes ☐ No	
Previous Outpatient Treatment	
Provider(s):	
When was treatment provided?	

Describe outcome of previous outpatient treatment.

Previous Inpatient Treatment:	
Where was treatment provided?	
Admit Date:	Discharge Date:
Describe outcome of previous inpatient treatment.	

VI. REQUESTED DATES AND SERVICES	
Requested Admission Date:	Number of Days Requested:
The recipient's treatment plan includes: ☐ Individual Therapy ☐ Group Psychotherapy ☐ Family Therapy	
Does the recipient have an Individualized Education Plan (IEP)? ☐ Yes ☐ No If "No," does the treatment plan include a referral for an IEP? ☐ Yes ☐ No	
If this is an out-of-state placement, are you prepared to produce written verification of unavailability of appropriate in-state services? ☐ Yes ☐ No	
What is the proposed treatment for this recipient?	
Describe the recipient's discharge plan:	

Residential Treatment Center

Certificate of Need

REQUESTED ADMISSION DATE: _____ /_____ /_____

SERVICE TYPE: ☐ Inpatient Psychiatric ☐ Residential Treatment Center (RTC) Initial Request

RECIPIENT INFORMATION

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

CASE MANAGER / REFERRING PROVIDER INFORMATION

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

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.