PRTF PRIOR AUTHORIZATION FORM

Authorization DOES NOT guarantee payment or current eligibility

Date Requested:		Timeline for clinical information to be submitted to Telligen: **PRTF ADMISSION:** Completed PRTF Prior Authorization form should be submitted 3 to 7 calendar days prior to requested admission date. **Required for submission:** **MD order for admission & psychiatric evaluation** (evaluation must be current; within 30 days of admission and completed by a child/adolescent psychiatrist)
Admission Date		
Facility Name:		
Facility NPI #:		
Facility UR Rep:		
Phone #		
Fax #		
Requested Days:		
Projected DC Date:		

The facility has agreed to share the status of the authorization with the client/guardian

PRTF Facility	
Attending physician (first and last name):	
Physical Address:	Physician Phone #:

Client Information			
Name:	DOB:	Age:	Sex: ☐ Male ☐ Female
Address:	Phone #:	Medicaid ID #:	Social Security #:
Legal guardian/relationship to client:	Guardian's Address		Phone #:
Parent's Name (If different):			Phone #
Client in DFS custody? ☐Yes ☐No	If yes, DFS worker/probation officer's name:		Phone #:
Is admission court ordered? ☐Yes ☐No			

GAL Name:	GAL Phone #:
Client currently enrolled in Medicaid Care Management Entity (CME)?: ☐No ☐Yes, enrollment date:	
CME Provider:	

Facilitator:	Facilitator Phone #:	Facilitator Email:

Primary Care Physician		
Physician Name:		Visit frequency:
Clinic/Practice Name:	Physician/Provider Phone #:	Provider notified of admission? ☐Yes ☐No

Psychiatric Provider (psychiatric medication management)		
Physician Name/Provider name and credentialing:		Visit frequency:
Clinic/Practice Name:	Physician/Provider Phone #:	Provider notified of admission? ☐Yes ☐No

Outpatient Providers (minimum 6 months of documented effort to treat with maximum intensity of services outpatient)				
Individual Therapy	Provider Name:	Phone #:	Start Date:	Visit Frequency:
Family Therapy	Provider Name:	Phone #:	Start Date:	Visit Frequency:
Other (Describe)	Provider Name:	Phone #:	Start Date:	Visit Frequency:

Inpatient Treatment History			
Facility Name:	Admit Date:	Discharge Date:	Reason for Admit:
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Additional Outpatient Community-Base Interventions (resources / support services) *(describe all attempts to treat at a lower level of care not previously described, such as school interventions, mentor, group therapy, Alateen, wrap-around, case management, waiver supports, etc.)*			
Provider/Program Name:	Services Provided:	Dates Utilized:	Phone #:
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Reason(s) for lack of success at a lower level of care	
□ Unremitting psychiatric symptoms	□ Co-morbid active substance abuse disorder
□ Co-morbid unmanaged medical condition	□ Non-adherence to medications
□ Non-adherence to therapeutic aspects of treatment plan	□ Lack of natural support system
□ Appropriate level of care / service unavailable in client's community	
□ Other:	

Evaluations/testing related to psychiatric or education needs (required documents, if available) (psychological, neurological, psychosexual, IQ, speech, hearing, language, etc.)			
Evaluation/Testing:	Provider	Date of Service	To be done after admit: □ Yes □ No
Evaluation/Testing:	Provider	Date of Service	To be done after admit: □ Yes □ No

DSM V Diagnoses	
Code:	Diagnosis:

Additional relevant diagnostic information (including medical)

Education			
Client's Home School District:	Grade:	IEP in Place ☐ Yes ☐ No	School notified of admit: ☐ Yes ☐ No
IEP/educational assessments, other school records received from home school district: ☐ Yes ☐ No	Barriers to notification/school contact:		
What educational assessments will be completed upon admission?			

Clinical *Describe the severely distressing, disruptive and/or immobilizing symptoms requiring admission.* *The described symptoms must be persistent and persuasive.*

Substance Use/Abuse History			
Substance:	Actively Using?	Estimated time & frequency of use:	History of withdrawal symptoms?
	□ Yes □ No		
	□ Yes □ No		
	□ Yes □ No		

Trauma/Abuse History			
Physical: □ Yes □ No	Emotional: □ Yes □ No	Sexual: □ Yes □ No	Neglect: □ Yes □ No
Describe abuse (what, when, by whom):			
Was this abuse reported: □ Yes □ No If no, describe facility's plan to report abuse:			
Who was abuse reported to?			
When was abuse reported?			

Medications *(Medication name, dosage, frequency and date started if known; for PRN medications specify the reason and prescribed frequency; for discontinued medications include DC date.)*
1.
2.
3.
4.
5.
6.

Family Therapy
Who has been identified to participate in the required weekly family therapy sessions?
Has requirement of 60 minutes of family therapy a week been discussed? ☐ Yes ☐ No

Natural Support System
Describe client's natural support system including supportive family, neighbors, friends, mentors, religious community etc.:

Discharge Plan – A viable discharge plan is required upon admission
Who will the client be discharged to? Please provide their contact information if it has not been provided elsewhere on this form:
Is it reasonable to expect the applicant could be safely served in his/her home, school and community with access to intensive, community based, behavioral health and care coordination services (including evolving crisis plans) that are individualized to the youth and family's particular needs? ☐ Yes ☐ No
If the answer above is no because the youth currently needs a higher level of care: Is it reasonable to expect this youth could be safely served in the community upon discharge, with intensive, community-based services individualized to youth and family needs in place? ☐ Yes ☐ No
Name of Physician/Psychiatrist who responded to the above 2 questions:
Date of response:
Describe the transition steps needed before the client returns home:
If the client is being discharged to a step-down placement, identify the placement and phone number:
Is there a safety plan in place? ☐ Yes ☐ No (if yes, attach a copy)

Waiver and CME Supports
Has the parent/guardian been referred to CMHW: □ Yes □ No (application should be made 2-3 months before discharge) Main office phone number: (307) 459-6162 Website: http://health.wyo.gov/healthcarefin/medicaid/childrens-mental-health-waiver/
If applicable, has the parent/guardian been referred to the Development Disability Child Waiver? □ Yes □ No (application should be made 2-3 months before discharge) Main office phone number: (307) 777-7115 Website: http://health.wyo.gov/ddd/index.html
For more information on the Medicaid Care Management Entity, see the CME website: http://www.magellanofwyoming.com/ For information regarding how to refer, please discuss with Telligen Care Manager

Submit the completed form to Telligen via the Qualitrac Portal

Forms can be located on line at http://www.wymedicaid.telligen.com