

# Psychiatric Residential Treatment Facility (PRTF) Authorization Request Form

Fax completed form to the AmeriHealth Caritas Louisiana Behavioral Health Utilization Management (BH UM) department at **1-855-301-5356**. If you have any questions, please contact BH UM at **1-855-285-7466**.

All PRTF authorizations are based on medical necessity of services. The below supporting clinical documentation must be submitted with the PRTF Authorization request form. **All required clinical information is the responsibility of the referring and/or requesting provider to obtain and provide a medical necessity determination to BH UM. Failure to submit all clinical documentation may result in a processing delay.**

1. The request must include the below supporting documentation to be reviewed for medical necessity:
  - a. Most recent psychosocial and/or diagnostic assessment by an licensed mental health practitioner (LMHP) within the last six months.
  - b. Court order for placement and custodial orders, if applicable.
  - c. Most recent IEP/504 plan, if applicable.
  - d. Psychological and/or neuropsychological testing, if applicable.
2. Upon receiving all clinical information, BH UM will schedule a telephonic review to determine medical necessity. The telephonic review must include the LMHP who has completed a face-to-face assessment/session with the member.

Referral information		
Date of referral:	Referral contact:	
Referring facility/agency:	Phone:	Fax:

Demographic information (please print)			
Child's name:	Date of birth:	Age:	Medicaid ID:
Ethnicity:	Language:	Diagnosis:	
Home address and phone number:			
City:	State:	ZIP:	
Custody (Department of Children and Family Services [DCFS], parents, other family, juvenile court, other agency):			
Name of custodian:	Relationship:	Phone:	

LMHP recommending PRTF level of care	
Provider name:	Phone:
Contact person:	Phone:
NPI or tax ID number:	Fax:
Date the LMHP completed a face-to-face assessment or session with the member?	
What is the member's current status or placement?	



Reason for referral		
Current mental health and/or substance use disorder symptoms (frequency, dates, or consequences that led to a referral for PRTF):		
What are the contributing factors to the main clinical need or problem?		
What are the goals for the PRTF and recommended interventions for the contributing factors indicated above?		
Current living situation:		
Family history (psychiatric, substance use, domestic violence, family stressors, etc.):		
Family's role in treatment:		
DCFS, JOC, Legal FINS, or OJJ involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate type:	Contact name:	Phone number:
Child's current grade level:	Current school:	Special education classification? <input type="checkbox"/> Yes <input type="checkbox"/> No
Academic, behavioral, or social functioning in school (note any suspensions or expulsions):		

All medication	Dose	Schedule	Prescribing M.D.	Target symptoms



Treatment history	Yes/no/unknown	Provider	Service date
Psychiatric hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Substance use treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Mental Health Reporting System (MHRS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Coordinated System of Care (CSOC)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Psychiatric Residential Treatment Facility (PRTF)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Therapeutic group home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Crisis stabilization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Therapeutic foster care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Psychological and/or neuropsychological testing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Medical treatments/concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

A medical necessity determination will be made after a review of all required clinical information and a telephonic review. Once a medical necessity determination is made, the referral source and/or PRTF — if one has accepted the member — will be notified within 48 hours of the determination. If the PRTF admission is determined medically necessary and a PRTF placement has not been solidified, this will be required of the referral source.

