Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

Residential Re-Authorization Form

Upon completion of this form **please fax to 1-833-966-4342**.

Facility Name		
Facility NPI #		
Contact Person Name		
Phone #		
Fax #		
Level of Care / CPT Code Requested		
Modifiers		
Request Date		
Member Name/DOB		
Attending Physician Name / #		
Other Insurance *(any changes)*		
Guardian name and phone# *(any changes)*		
RCST/phone # *(any changes)*		
Court Commit / Ordered *(any changes)*	**Yes** ☐ **No** ☐	**If yes, please attach changes only**

Updated DX

1.
2.
3.
4.
5.
6.

Current Symptoms/Behaviors/Functional Deficits/Needs that necessitate continued stay at current level of care. Please tell us why member can't be treated at a lower level of care:
If applicable — bio/foster family contact (can include phone calls/passes/FT sessions):
List or narrative of reports below (This can consist of therapy/psych notes with current updates/progress)
Behavioral Health Report:
Mental Health/Trauma Report:
Education Report:
Significant incidents from the last reporting period:
Is member on any special precautions?

Current Medications:

Name and dose of medication	Start date	Adjustments to Med	Reason for Medication	Any significant updates

Is member compliant with taking meds:	**Yes** ☐ **No** ☐
If no, explain:	
Any comments regarding meds:	

OUTPATIENT APPOINTMENTS IN LAST REPORTING PERIOD

Provider	Service	Date
Comments/concerns:		

DATES OF SESSIONS THIS REPORTING PERIOD

Individual Therapy	Group Therapy	Family Therapy	Treatment Plan Meeting	Other

Treatment Plan Updates/Notes:
Discharge Plan/Follow Up:
Discharge disposition:

What movement has there been regarding discharge during this reporting period?
Barriers to discharge:
Tentative timeline for discharge: