Psychiatric Residential Treatment Facility Prescreening Request Form

Submit completed form by fax to **1-833-974-0059**.

Instructions:

This Certification of Need is a requirement of federal regulations found at 42 CFR 441.152. Specifically, the need for inpatient psychiatric services must be established and documented by a team of professional personnel, as described below. Accordingly, this form must contain the signatures and credentials of either independent or interdisciplinary team members who are knowledgeable of the circumstances necessitating admission. Please attach Certification of Need and any supporting documents to demonstrate requirements for psychiatric residential treatment facility (PRTF) services.

Upon receipt of your request, a Humana team member will contact you within 24 hours to advise if additional information is needed or if information received supports medical necessity for PRTF services.

Today's date:	
Name of requestor:	
Secure fax:	Phone:
Please note: Provide appropriate contact information, including best working phone number for Humana staff to contact you if clarification or additional information is needed to complete the request.	

Member information		
Last name:	First name:	
Humana ID:	Medicaid ID:	Date of birth:
Parent/guardian name:		Phone:
Member's living arrangements: ☐ At home with guardian ☐ Group home ☐ Foster home		
After their stay in a residential treatment facility, can the member return to their home? ☐ Yes ☐ No		
Start date of service:	End date of service:	

For members with a home- and community-based services waiver, please include support/service coordinator/targeted case manager information.

Requesting provider/facility		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider		
Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	
Support coordinator name:	Phone:
Doctor or clinician to provide PRTF certification review and reason of need for PRTF services:	
Please explain the clinical presentation and behavior history of the member that supports the need for this level of care.	
Please advise if member has had previous treatment episodes in PRTF and provide rationale for additional PRTF services.	

Diagnosis code(s) and date(s) of service (DOS)			
ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:

* ICD-10 codes are from the International Classification of Diseases, Tenth Edition.

Standing medications:

Admitting hospital interdisciplinary team

Certification for an individual who applies for Medicaid at or during admission may be made by the admitting hospital's interdisciplinary team. At a minimum, this team must include either (1) a board-eligible or board-certified psychiatrist; OR (2) a clinical psychologist who has a doctoral degree and is a licensed physician; OR (3) a licensed physician with specialized training and experience in the diagnosis and treatment of mental diseases who is a psychologist with a master's degree in clinical psychology and who has been certified by the state or by the state psychological association. The team must also include (1) a registered nurse with specialized training or one year's experience in treating mentally ill individuals; OR (2) a psychiatric social worker, a licensed occupational therapist with specialized training or one year's experience in treating mentally ill individuals, or a psychologist with a master's degree in clinical psychology or who has been certified by the state or the state psychological association.

The patient named above requires care in a mental facility/program. The following requirements are met:

1. Ambulatory care resources available in the community have been tried or are currently inadequate to meet the treatment needs of this patient (the availability or lack of outpatient resources is not a determining factor for Medicaid reimbursement); and
2. Proper treatment of this patient's psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist or a physician under the supervision of a psychiatrist; and
3. The services can be expected to improve this patient's condition within a reasonable period of time or prevent further regression to the extent that services will no longer be needed.

Independent team

(Not associated with admitting hospital—if Medicaid-certified)

Date _____ Signature _____ (name and credentials)

Date _____ Signature _____ (name and credentials)

Admitting hospital interdisciplinary team

(If not Medicaid-certified)

Date _____ Signature _____ (name and credentials)

Date _____ Signature _____ (name and credentials)

Date _____ Signature _____ (name and credentials)