REQUEST FOR PCP AUTHORIZATION OF Residential Treatment SERVICES

Name of PCP **CFYF #**

Name of Patient **Birthdate**

Insurance Carrier and Pol. No. **Medicaid No.**

For what services is authorization requested (evaluation or treatment)? *(Be as specific as possible re: type of evaluation or, for therapy, units or frequency. Attach extra pages, as needed.)*

Evaluation and treatment as recommended by the multidisciplinary team led by the staff Psychiatrist or staff Physician for residential inpatient treatment including ACH Children's hospital clinics, or PCP services.

Name and qualifications *(O.T., P.T., etc.)* of provider or contractor to deliver these services:

Qualified Mental Health Professional, Paraprofessionals, and Psychiatrist or Staff Physician

Primary diagnosis

Secondary diagnosis

Justification for requested services (*Why are they needed? Abnormal findings? Results of current evaluation? Attach current evaluation, if available*):

For therapy services, what is the goal of therapy? *(Be specific re: outcomes and timetable. Attach extra pages as needed.)* *Increase prosocial behaviors and decrease maladaptive behaviors*

Centers for Youth and Families

Signature of requesting provider ______________________________ **Date** ________________

Address of requesting provider **P.O. Box 251970, Little Rock AR 72225-1970** **Voice (501) 666-8686**

RETURN SIGNED FORM TO: **Please fax to (501) 663-6503**

PCP AUTHORIZATION

Services approved as requested

X **Services approved as amended:** **For Services Beginning on** ______________________

Services Denied

Reason for denial:

PCP Signature ___________________________________ **Date** __________________

Medicaid Provider # ______________________________ **NPI #** ___________________