OKLAHOMA
Health Care Authority

PRIOR AUTHORIZATION ADMISSION REQUEST

(ONLY TYPED REQUESTS ACCEPTED)

Request Type:	CHOOSE REQUEST TYPE				
Date Submitted:		**Is Medicaid Primary?**	☐	Yes	☐ No

Provider Name:			**Provider ID w/ Service Loc:**	
Reviewer Name:			**Reviewer Phone w/ Ext:**	
Member Name:			**Member ID:**	
Date and Time of Assessment:	Date:	Time:	**Member Date of Birth:**	
			Member Age:	
Custody Status:			**Custodial Agency:**	
Is member a Native American?	☐ Yes	☐ No	**County of Residence:**	

Date of Admit:		Est Date of Discharge:		Est LOS:		Attending MD:	

Requested Start Date:	Requested End Date:	Requested Days:

List the guardian's name and relationship to member including their address and phone number. For members 18 to 20 years old, list personal contact information as well as their emergency contact. If DHS/OJA involvement, list caseworker contact info including email address.
How was the member referred and who participated in the admission assessment?
What is the primary reason for admission? Include any recent stressful life events triggering and/or exacerbating the member's condition?

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
oklahoma.gov/OHCA
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

DSM-5 Mental Health and Medical diagnoses with accompanying specifiers (e.g., 296.33 Major Depressive Disorder, recurrent, with mood-incongruent psychotic features). List in order of acuity with the first diagnosis being the primary focus of treatment.	
Primary Diagnosis Code:	**Diagnosis Description:**
Diagnosis Code:	**Diagnosis Description:**
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Describe positive and negative psychosocial and environmental factors impacting diagnosis, treatment or prognosis.	
Member's Estimated IQ (e.g. above average, average, below average. If below average, please provide details.)	

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CURRENT CLINICAL – AS EVIDENCED BY SPECIFIC DATES/BEHAVIORS
RESERVE FOR 1) RATIONALE FOR SPECIALTY ADMITS 2) RECONSIDERATION REQUESTS - provide new and/or additional clinical information supporting your original request. Only information occurring prior to the time of admission will be considered. 3) 1:1 REQUESTS – include a) list specific behaviors that require 1:1 with clinical justification b) specific plan to transition member off 1:1 c) expected date to discontinue 1:1. d) continued authorization of 1:1 requires updated information for items a, b, and c every PA request.
Describe member's appearance, mood, affect and behavior during admission assessment.
Suicidal Ideation/Homicidal Ideation (Document plan, means, mitigating factors, frequency, duration, and prior hx of suicidal/homicidal ideation/attempts):
Self-Mutilation Behavior (frequency/duration/triggers):
Sexual Acting Out (frequency/duration/triggers):
Psychotic Behaviors resulting in danger to self or others or inability to care for self:
Physical Aggression/Tantrums (frequency/duration/triggers):
Substance Use (frequency/duration/triggers):
List current medications (include strength, route, frequency, prescriber):
Current Eating and Sleeping Patterns:
School Functioning (attendance, suspensions, IEPs, special arrangements, etc.):

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Delinquent Behaviors (include unlawful activities, police involvement, probation, jail and/or detention occurrences, etc):
Other relevant clinical information to support treatment at this level of care. Please do not duplicate information that has already been documented elsewhere in the request.
FOR RTC ADMITS ONLY: Have less intensive treatment programs (e.g. outpatient, systems of care/ wraparound, day treatment, crisis center, etc.) been thoroughly tried? If Yes, describe attempts in detail. If No, provide the reasons why these programs have not been attempted.
Who will be participating in family therapy? Are their any barriers to participation? How will those barriers be addressed?

HISTORY OF PRIOR BEHAVIORAL HEALTH AND MEDICAL TREATMENT
Outpatient Behavioral Health including wraparound services (include dates/provider names). Describe member and guardian's adherence to most recent outpatient services including how often the member was seen for counseling and psychiatry and by whom. What was the last service date?:
Inpatient Behavioral Health (include dates/provider names):
Psychological Testing Results (past/present/pending including dates/provider names):
Medical History (significant health conditions/events with approximate dates):

DISCHARGE PLANNING
Where and with whom will the member live following discharge?
Expected Aftercare Service Plan:

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