OKLAHOMA
Health Care Authority

PRIOR AUTHORIZATION EXTENSION 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:**	
Attending MD:		**Member Age and DOB:**	
Custody Status:		**Custodial Agency:**	
Is member a Native American? ☐ Yes ☐ No		**County of Residence:**	

Date of Admission:		Est Date of Discharge:		LOS:	

Requested Start Date:	Requested End Date:	Requested Days:

RESERVE FOR 1) RECONSIDERATION REQUESTS - provide additional clinical information supporting your original request. Only information occurring prior to the time of the present request will be considered. 2) TRANSFER REQUESTS - provider rationale for transfer. 3) RESPOND TO OHCA PHYSICIAN/REVIEWER QUESTIONS. 4) 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.

REVIEW PERIODS FOR THE RESERVE FIELD

Enter Request Start Date:	
Enter Request Start Date:	
Enter Request Start Date:	

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 info as well as their emergency contact. If DHS/OJA involvement, list caseworker's contact info including email address.

What was 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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List changes to the member's diagnosis since the last review.	
Member's Estimated IQ (e.g. above average, average, below average. If below average, please provide details.)	

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DOCUMENT DISCHARGE PLANNING ACTIVITIES specific to the member for the current review period e.g. arrange living arrangements after discharge, set up aftercare services/appointments, develop safety plan for post discharge, communications with DHS/OJA worker about post-discharge plans. "Participated in Discharge Planning Group" is too general.	
REVIEW PERIODS TO DOCUMENT DISCHARGE PLANNING ACTIVITIES	
Enter Request Start Date:	
Enter Request Start Date:	
Enter Request Start Date:	
Where and with whom will the member live following discharge?	

CURRENT CLINICAL AS EVIDENCED BY SPECIFIC BEHAVIORS AND THE DATES THE BEHAVIOR OCCURRED.	
Suicidal Ideation/Homicidal Ideation *(cite specific statements made by member, attempts, the date occurred, the events leading up to the behavior, and special precautions)*	
Enter Request Start Date:	
Enter Request Start Date:	
Self-Mutilation Behavior (cite examples and the date occurred, the events leading up to the behavior, and special precautions)	
Enter Request Start Date:	
Enter Request Start Date:	
Sexual Acting Out (cite examples and the date occurred, the events leading up to the behavior, and special precautions)	
Enter Request Start Date:	
Enter Request Start Date:	

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Psychotic Behaviors (cite examples and the date occurred, the events leading up to the behavior, and special precautions)	
Enter Request Start Date:	
Enter Request Start Date:	
Physical Aggression/Tantrums (cite examples and the date occurred, the events leading up to the behavior, special precautions and list seclusions, physical or chemical restraints, documentation of verbal aggression must include specific statements made by member)	
Enter Request Start Date:	
Enter Request Start Date:	

Date:	
List current medications documenting purpose, strength, route and frequency. If medication changes were made from the previous review give the reasons why.	
Medication:	**Purpose, strength, route and frequency:**
Passes: Provide dates, length of passes, location, and with whom. If no passes occurred *(even on site)***, provide reasons for why not? State if the pass was considered successful or unsuccessful. Document significant behaviors occurring during and immediately after the pass.**	
Enter Request Start Date:	
Enter Request Start Date:	

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Describe member's guardian *(parent/foster parent/DHS or OJA caseworker)* **involvement in member's treatment noting therapy session attendance, visiting client outside of therapy, calling between visits, and guardian's desire for member to return home after discharge:**	
Enter Request Start Date:	
Enter Request Start Date:	
Other clinical information to support treatment at this level of care. Please do not duplicate information that has already been documented elsewhere in the request.	
Enter Request Start Date:	
Enter Request Start Date:	

Physician Notes with Dates:
Individual Therapy Notes with Dates:
Family Therapy Exception *(FTE): To request a FTE, provide a) the specific circumstances preventing the guardian from participating and b)* a detailed, alternate proposal to include the guardian in the member's treatment. If you already have an approved FTE on file for this review period, please note it.
Family Therapy Notes *(include date of the session and who attended, if guardian does not show up for the session, please document the reason why):*

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BEHAVIORAL HEALTH AND MEDICAL HISTORY
Outpatient Behavioral Health TX including systems of care/wraparound (dates/provider names). Describe member and guardian's adherence to most recent outpatient behavioral health services. What was the last service date?:
Inpatient Behavioral Health TX *(dates/provider names):*
Psychological Testing Results *(past/present/pending including dates/provider names*):
Medical History *(significant health conditions/events with approximate dates):*
Family History of Mental Illness:
Gestation or Pregnancy Complications *(e.g. premature birth, prenatal alcohol/drug exposure,etc.):*
Developmental History *(current developmental age, significant milestone delays, include providers and treatments used to address delays, received DDSD services or signed up for waiver, etc):*
Delinquent Behavior History *(include unlawful activities, police involvement, probation, jail or detention occurrences):*
Substance Use History:

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