Fax Transmittal Sheet

Nevada Medicaid and Nevada Check Up – Rehabilitation FA-11A Authorization Request

To:	Nevada Medicaid MH Rehab Program
Fax Number:	(866) 480-9903
Phone Number:	(800) 525-2395
From:	
Fax Number:	
Phone Number:	
Date:	
Number of Pages: (including this cover page)	

☐ **Urgent** ☐ **For Approval** ☐ **Please Comment** ☐ **Please Reply**

Comments

Nevada Medicaid and Nevada Check Up

Behavioral Health Authorization Request

(For provider types 14, 26 and 82)

Fax request to: (866) 480-9903 Questions? Call: (800) 525-2395

Request Date:	Recipient Name:

REQUEST TYPE: ☐ Initial Prior Authorization – Start date of services:_____

☐Concurrent Authorization ☐Unscheduled Revision

☐Reconsideration ☐Retrospective Authorization – Date of Eligibility Decision:_____

I. COORDINATING QMHP

Name:		Credentials:
NPI:	Phone:	Fax:
Address *(City, State, Zip)*:		

II. REQUESTING PROVIDER

Name:		Credentials:
NPI:	Phone:	Fax:
Requesting provider's group NPI:		

III. RECIPIENT

Name:	DOB:
Recipient Medicaid ID:	Age:
Recipient's Living Arrangements (e.g., group home, foster home, parents):	
Is the recipient in State custody? ☐Yes ☐No	Date recipient went into State custody:

IV. RESPONSIBLE PARTY

Organization/Legally Responsible Adult Name:	Phone:
Address *(City, State, Zip)*:	
Relationship to Recipient:	

V. ICD-10 DIAGNOSIS

(If using DC:0-3, use the appropriate crosswalk and enter the appropriate ICD-10 diagnosis code and disorder)

Primary Code:	Disorder:
Secondary Code:	Disorder:
Tertiary Code:	Disorder:
Clinical Assessor name and Credentials:	Date:

VI. ASSESSMENT SCORE

☐ CASII	Score:	Level:	Date:	
☐ LOCUS	Score:	Level:	Date:	
☐ ECSII or Other Assessment *(specify)*:		Score:	Level:	Date:
Clinical Assessor Name:		Credentials:		

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VII. SYMPTOMS AND SIGNIFICANT LIFE EVENTS *(List symptoms and/or significant life events that relate to the recipient's Axis I diagnosis and/or that brought the recipient to treatment, e.g., pertinent family information, developmental history, medical issues, sexual history, substance abuse and legal history.)*

VIII. TREATMENT PLAN AND RATIONALE *(Identify for each problem/behavior, long and short term goals, strength and psychosocial support progress or regression during the last authorized period.)*

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IX. CURRENT MEDICATION(S) *(List current medications/dosage. Attach additional sheets if needed to fully document all medications.)*

Medication Name	**Dosage/Frequency**
1.	
2.	
3.	
4.	
5.	
6.	

X. PREVIOUS AND CURRENT TREATMENT *(Describe previous treatment for psychiatric and pertinent medical conditions.)*

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XI. REQUESTED AND APPROVED TREATMENT *The requester will be deemed the point of contact for this authorization request and is responsible for dissemination of all information regarding this request*.

Recipient Name:	Recipient ID:
Requester Name:	
Requester Fax:	Requester's Group NPI *(must be Medicaid-enrolled provider group)*:
Servicing Provider Name:	Servicing Provider Fax:
Servicing Provider Name:	Servicing Provider Fax:
Servicing Provider Name:	Servicing Provider Fax:
Servicing Provider Name:	Servicing Provider Fax:

"Req." is an abbreviation for Requested Service. Enter your requested services on this row. "Units per day" multiplied by "Days per Week" multiplied by the total number of weeks in the entire date span equals "Total Units." "App." is an abbreviation for Approved Service. Nevada Medicaid will enter approved service information on this line after receiving your completed request.

	Code	Modifier	Servicing Provider Name	NPI/API		Start Date and End Date	Units per Day	Days per Week	Total Units	Authorization Number
1					Req.					
					App.					
2					Req.					
					App.					
3					Req.					
					App.					
4					Req.					
					App.					
5					Req.					
					App.					
6					Req.					
					App.					

Requester's Signature:			**Date:**
Date Received:	**Reviewer Initials:**	**Date Deferred to MD:**	**Date of Determination:**

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Request Date:	Recipient Name:

XII. SERVICE LIMITS

Are you requesting units above the established limits for the recipient's level of care? ☐ Yes* ☐ No

***If yes, complete the two questions that follow.** Such services must be prescribed on the recipient's Rehabilitation Plan and can only be prior authorized for up to 30 days.

Provide a one-year history of the recipient's inpatient psychiatric admissions and residential treatment:

Provide a 90-day history of the recipient's most recent outpatient psychiatric services: