



Prior Authorization Request for Additional or Specialized Units
Fax to: 866-543-2385

Authorization approves the medical necessity of the requested service only. It does not guarantee payment. The recipient must be eligible for Missouri Care on the date of service. Authorizations for additional units will begin no earlier than the date the request is received.		
Member name	Provider name	Signature / Date
Date of birth	Telephone #	Fax #
DCN (Medicaid) #	Address	
Current Psychotropic Medication(s)	Dose	Frequency
This is a request for: <input type="checkbox"/> Additional Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Interactive/Family Therapy for < 5 y.o.a.		
Please note the number AND frequency of units requested: _____ units, @ _____ units per _____		
Anticipated therapy termination date: _____ / _____ / _____		
Have you communicated with the PCP or other health care professional about treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No The "PCP Notification Form" is available at: http://www.missouricare.com/BHforms.html		
DSM IV-TR Multiaxial Diagnosis		
Axis I: Clinical Disorders or other Disorders that may be a Focus of Clinical Attention /		
Axis II: Personality Disorders, Mental Retardation		
Primary Diagnosis	Secondary Diagnosis	Additional Diagnoses
Is there evidence of substance abuse/dependence? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, has the member been referred to alcohol/drug treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Axis III: General Medical Conditions		
Does this patient have a general medical condition that affects the understanding or treatment of the condition(s) noted in Axis I or II? If so, list: _____		
Axis IV: Psychosocial and Environmental Problems (Please indicate any or all that apply):		
<input type="checkbox"/> Problems with primary support group <input type="checkbox"/> Problem related to social environment <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> Other psychosocial and environmental problems <input type="checkbox"/> Legal problems		<input type="checkbox"/> Economic problems <input type="checkbox"/> Educational problems <input type="checkbox"/> Occupational problems <input type="checkbox"/> Housing problems <input type="checkbox"/> Physical / Sexual Abuse
AXIS V: Global Assessment of Functioning Current: _____ Highest within the last year: _____		
Patient's response to treatment: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Excellent		
Patient's engagement in treatment: <input type="checkbox"/> None <input type="checkbox"/> Minimal <input type="checkbox"/> Limited <input type="checkbox"/> Positive <input type="checkbox"/> Optimal		
Quality of patient's support system: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Average <input type="checkbox"/> Good <input type="checkbox"/> Excellent		
Has the patient reported or exhibited any of the following within the last month? (Please indicate any or all that apply):		
<input type="checkbox"/> Suicidal ideation	<input type="checkbox"/> Homicidal ideation	<input type="checkbox"/> Physical assault of others
<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Property destruction	<input type="checkbox"/> Sexual assault of others
<input type="checkbox"/> Visual hallucinations	<input type="checkbox"/> Auditory hallucinations	<input type="checkbox"/> Paranoia/Delusions

*** Please attach to current assessment, treatment plan and the last three progress notes.**