Nebraska Medicaid Managed Care Program
Treatment Review & Authorization Request
Medicaid Rehab Option (MRO) and Peer Support Services

☐ Initial Authorization/Initial Clinical Assessment/POC
☐ Routine Request: (Up to 14 days)

☐ Re-Authorization/Plan of Care
☐ Urgent Request: (Within 72 hours) – Services are needed to stabilize the patient and prevent deterioration. Client needs significant and immediate supportive interventions.

Admission Date: _____ *Authorization Start Date_____ *Authorization End Date_____

Date of Request: _____

Managed Care Organization		
☐ **UHC** Phone: Fax:	☐ **Nebraska Total Care** Phone: Fax:	☐ **WellCare** Phone: Fax:
Provider(s) Information		
Provider/Facility Contact Person:	Phone #: Fax #:	Ordering Physician: NPI#:
Facility Information		
Name:	Medicaid Provider #:	NPI:
Member Information		
Name:	Date of Birth:	Nebraska Medicaid #:
Address:	Mobile Phone #: Home Phone #:	Contact Information: Relationship: Phone #:
Current Diagnoses		
Psychiatric /Co-Occurring Substance Disorder: **Medical**:		
Current Medications (medication name, dosage, frequency and prescriber): ☐ **None** ☐ **Yes. See Patient Med List**		
Justification for Authorization (Please submit treatment history and current clinical information to support authorization request):		
Expectation for consumer's improvement on treatment plan goals:		
Discharge/Transition Plan: (See attached Treatment Plan) Inpatient Admission in the last 90 days: ☐None ☐Yes		
Date of Last Assessment: **Significant changes in member's life since last assessment-** ☐ Not applicable. This is an initial request for services ☐ No significant changes ☐ Changes noted as follows:		
Referral to Clinical Care Coordination: ☐Yes ☐Not applicable		
Overall Motivation to Treatment: ☐ Good – Willing to follow up with recommendations and actively participate in treatment ☐ Somewhat - Wants treatment, but sometimes forgets to complete action steps/plans or follow up with recommendations ☐ Poor – ☐Has or had difficulties following up with treatment because of poor insight ☐Not fully engaged or is ambivalent about the benefits of treatment		

☐Denies having any problems and/or blames other for his/her problems
☐Other:

Family Involvement: ☐Active ☐ Limited ☐ None ☐ Not Applicable
Explain any less than active involvement:

Participation in Community Supports: ☐ Not at this time ☐ As follows:
Other Supports: ☐ None at this time ☐As follows:

Treatment Request

Treatment Request: please check service, units, frequency and weeks being requested.

☐**Assertive Community Treatmen**t:_____

1. Service Code being requested: H0040 or H0040-52 2. Number of Units: _____ 3. Frequency: _____ _____ (weeks)

☐**Psychosocial Rehabilitation Services (Day Rehab):** _____

1. Service Code being requested: H2017 or H2018 2. Number of Units: _____ 3. Frequency: _____ (weeks)

☐**Psychiatric Residential Rehab:** _____

1. Service Code being requested: Нллмфпl9 2. Number of Units: _____ 3. Frequency: _____ (weeks)

☐**Peer Support:** _____

1. Service Code being requested: H0038 2. Number of Units: _____ 3. Frequency: _____ (weeks)

☐**CommunitySupport:** _____

1. Service Code being requested: H2015-HE, H2015-HF 2. Number of Units: _____ 3. Frequency: _____ _____ (weeks)

Treatment Review
(Complete only when requesting Re-Authorizations)

Number of appointments attended since last authorization: _____

Type of Services and Units/Encounter used from last authorization:

☐ACT _____ # of Units ☐ Psych Res Rehab _____ # of Units ☐ PRS (Day Rehab) _____# of Units
☐Peer Support Services _____ # of Units ☐ Community Support Services _____# of Units

Other treating provider Signature:	**Date:**