

NARBHA PRIOR AUTHORIZATION REQUEST FORM 3.14.5

Admission Level I Inpatient Hospital/Subacute

Instructions: This form is completed by RA staff prior to admission for non-emergencies or within 72 hours for emergency admissions to facilities outside of NARBHA GSA and faxed to NARBHA UM at fax (928) 214-1166

Member Name: _____	Member ID: _____
AHCCCS ID: _____	Responsible Agency: _____
Proposed Facility Name _____	Number of Days Requested: _____
Date of Admission _____	Estimated Length of Stay (days): _____

Type of Admit: **Non-Emergency** **Emergency**

Name of physician to contact for more information: _____ **MD phone/pager #:** _____

A person must meet ALL criteria in Sections A and C, D, E, at least ONE of the criteria in each of Sections B, for admission to a psychiatric acute hospital or subacute facility.

A. DIAGNOSIS: Axis I _____ Axis II _____ Axis III _____
(A specified diagnosis within the range of 290 through 316.99 is required to be documented at the time of discharge from inpatient services.)

B. BEHAVIOR AND FUNCTIONING (Must choose at least one)

1. Imminent risk of danger to self or others as a result of a behavioral health condition as evidenced by:
 - Current suicidal ideation, behavior or intent; **OR**
 - Current homicidal or significant assaultive ideation, behavior or intent; **OR**
 - Immediate physiologic jeopardy; **OR**

2. Disturbance of mood, thought or behavior which renders the person acutely incapable of developmentally appropriate self-care or self-regulation; **OR**

3. Disturbance of mood, thought or behavior that requires an assessment or medication trial that cannot be safely or adequately implemented in a less restrictive setting; or Level of functioning that does not meet the above criteria, but less restrictive levels of care suitable to the behavioral health needs of the person are unavailable, or the person cannot return to his or her residence due to risk of harm to self or others due to a treatable behavioral health disorder, or there is a likelihood of imminent behavioral decompensation.

EXPLANATION: _____

C. INTENSITY OF SERVICE (Must meet this criteria)

This type of service provides planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. Treatment should be in the least restrictive type of service consistent with the person's need and therefore should not be instituted unless there is documentation of a failure to respond to or professional judgment of an inability to be safely managed in a less restrictive type of service. **EXPLANATION:** _____

D. EXPECTED RESPONSE (Must meet this criteria)

The client's behaviors and symptoms, which were identified as reasons for admission, can be effectively treated by medically indicated treatment available in this setting. The treatment can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed.

EXPLANATION: _____

E. Discharge Plan with specific discharge criteria and recommendations for aftercare treatment that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment: _____

Other information: _____

Provider Signature _____ **Date:** _____