NARBHA Admission and Continued Authorization Request Form

PM Form 3.14.5

Level I Inpatient Hospital/Subacute

Instructions*: Please fax to NARBHA UM at 928-214-1166. It is necessary to submit the following documents:* ***Admission****:* ☐ *MD notes and clinical admission information.* ***Continued stay auth****:* ☐*Psychiatric Evaluation* ☐*Medication sheets* ☐ *Treatment plan with discharge plan and criteria* ☐ *Progress Notes* *Incomplete forms could result in delay of payment.*

Member Name:	**Member ID:**
AHCCCS ID:	**Responsible Agency:**
Facility Name:	
Number of Days Requested:	
Date of Admission:	**Estimated Length of Stay (days):**
Name of MD/NP/PA to contact for more information:	**MD phone/pager #:**
Requestor Name:	**Phone/Pager #:**

I. DIAGNOSIS: **Axis I**: **Axis II:** **Axis III:**

II. 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.

Must Give Explanation:

III. INTENSITY OF SERVICE (Admission Only) (Must meet 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**.** **Must Give Explanation**:

IV. **EXPECTED RESPONSE (Admission only)**

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☐ 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.
Must Give Explanation:

Member Name:

Continued Stay Authorization

For Continued stay only

INTENSITY OF SERVICE (must meet one)
There is documented evidence that the person requires at least one of the following:

☐ Continued planned, comprehensive assessment or treatment involving close daily psychiatric supervision and 24 hour medical supervision. This may be as a result of a change in diagnosis, treatment failure, or newly-discovered aspect of the person's case necessitating a significant change in the treatment plan; **OR**

☐ Close, continuous, 24 hour skilled medical/nursing supervision of the person's behaviors, which are due to a behavioral health condition, in order to prevent injury to the person or others; **OR**

☐ Pharmacotherapy which requires continuous, skilled medical/nursing supervision for safe, effective use; **OR**

☐ Skilled nursing observation and care in the management of disturbances of mood, thought or behavior which cannot be provided by non-medical personnel; **OR**

☐ Repeated use of physical restraint; **OR**

☐ Psychiatric acute hospital or sub-acute facility services may be continued if the person no longer requires the type of service provided in a psychiatric acute hospital or subacute facility but there is not an available lower intensity of services suitable to the behavioral health needs of the person or the person cannot return to the person's residence because of a risk of harm to self or others.
Must give explanation:

EXPECTED RESPONSE: *continued stay only*.
There is documented evidence that: (must meet)

☐ Active treatment is provided that is reducing the severity of disturbances of mood, thought or behavior which were identified as reasons for admission; **OR**

☐ There has been a re-evaluation and subsequent change in the treatment plan.

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☐ There is still an expectation that continued treatment in this type of service can reasonably be expected to improve or stabilize the patient's condition so that this type of service will no longer be needed; **OR**

☐ There is no less restrictive type of service available to safely meet the person's behavioral health needs.
Must give explanation:

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**: Must give details of discharge plan:**

Provider Signature and Title: **Date:**