

**NARBHA Level I Residential Treatment Center Continued Stay
Prior Authorization Request Form 3.14.8**

Instructions: This form is completed by RA staff prior to end of previous authorization period and faxed to NARBHA UM at fax (928) 214-1166

Member Name: _____	Member ID: _____
AHCCCS ID: _____	Responsible Agency: _____
Facility Name: _____	Number of Days Requested: _____
Date of Admission: _____	Estimated Total Length of Stay (days): _____
Name of physician to contact for more information: _____	MD phone/pager #: _____

A person must meet ALL criteria for continued stay in Level I Residential Treatment Center.

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 meet all)

- Symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature; **AND**
- are consistent with a DSM IV-TR diagnosis (within the range of 290 through 316.99); **AND**
- continue to require residential 24-hour psychiatric treatment under the direction of a psychiatrist.

C. In addition, all of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:

- Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the child/adolescent; **AND**
- The child/adolescent does not require a level of medical or professional behavioral health supervision that surpasses that which is available at a Level I Residential Treatment Center; **AND**
- The continued stay is not used primarily and in a clinically inappropriate manner as an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior; the equivalent of child protection, safe housing, permanency placement, or an alternative to parents'/guardian's or other agency's capacity to provide for child or adolescent; or an intervention when other outpatient care is available and not being utilized.

EXPLANATION: _____

D. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT

- The child/adolescent is receiving services which are improving his/her psychiatric condition in order to achieve discharge from residential status at the earliest possible time and facilitate his/her return to outpatient care and/or family living. The professionally developed and supervised individual service plan has been changed (revised) if necessary to respond to any identified lack of progress.

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. (Please attach treatment plan with D/C plan) _____

Other: _____

Provider Signature: _____ **Date:** _____
