Authorization Form

Partial Hospital Program (PHP)

Date of Request: _____

Member Information:

Member Name		Member Date of Birth		Medicaid ID Number	

Care Coordinator Information (if known):

Care Coordinator Name		Care Coordinator Agency	
Care Coordinator Phone		Care Coordinator Email	

Person Completing Form:

Name		Title		Agency	
Telephone Number		Fax Number		Email	

PHP Provider being requested:

Provider Name			Provider Address		
Provider Phone Number		Provider Fax		Provider NPI	

Is Provider: ☐ Par ☐ Non-Par* ☐ ODM Registered

**If provider is Non-Par, please provide information on the person who has the authority to negotiate Single Case Agreements at your program:*

Name		Phone Number	

Start Date / Length of Stay:

Anticipated Start Date		Anticipated Length of stay	

Service Codes to be used and associated units:

Diagnosis:

Psychiatric symptoms/behaviors:

Please indicate date when member was last seen by a psychiatric provider. Include summary of symptoms and mental status at that time. List any treatment recommendations made by that provider including therapeutic interventions and medications. If member is currently in the inpatient psychiatric hospital, please also note the date that the member was deemed clinically ready for discharge by the inpatient psychiatric provider, and their detailed discharge recommendations.

Clinical Reason PHP is being requested:

Please explain why the member needs PHP at this time. Provide detail why less intensive outpatient services are not appropriate, and why member needs this level of clinical support.

Please describe other services or providers considered and the outcome:

List any other services or providers that were contacted and indicate their response. Explain if these services or providers were preferred to PHP and/or their availability.

Are psychiatric services going to be billed separately: ☐ Yes ☐ No

Once completed, please fax this form to 1-855-948-3770.