Magellan HEALTHCARE SM

Service Request Application (SRA) for:
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY AND THERAPEUTIC GROUP HOMES
INITIAL REQUEST

ALL ITEMS ARE REQUIRED

After response is entered, use the **Tab key** to advance to next item.

INDIVIDUAL INFORMATION		PROVIDER INFORMATION	
Member First Name		Provider Name	
Member Last Name		Clinical Contact Name	
Medicaid Number		Provider MIS#	
Member Date of Birth		Provider Tax ID#	
		Provider NPI	
Sex	◯ Male ◯ Female	Provider Phone	
Member Phone		Provider Email	
Member Address City, State & Zip Code		Service Address City, State & Zip Code	

CLINICAL INFORMATION	
Procedure Code	◯ **99221** ◯ **99231** ◯ **H2020 HW** ◯ **H2020 HK** ◯ **H2022 HW** ◯ **H2022 HK**
Primary Diagnosis	
Secondary Diagnosis	
Requested Units	
Requested Start Date	
Requested End Date	
Is CSA paying for any portion of this stay?	◯ Yes ◯ No If yes, Locality Code:
Is this an EPSDT funded service or stay?	◯ Yes ◯ No ◯ Not Applicable

Intake

1. Admission date to this facility:

2. Is this a request from an out-of-state provider? ◯ Yes ◯ No
   a. If yes, complete the attached "Out-of-State Provider Requirements Form" (pg. 4 of this form).

3. Is this a retro review request? ◯ Yes ◯ No
   a. If yes, when was referral made to IACCT?

4. Have you submitted an SRA for this service and for this individual within the last 30 days which was not approved? ◯ Yes ◯ No
    a. If yes, describe what changes have occurred to indicate that this service is now necessary?

5. Are you requesting a 1:1 under EPSDT for this individual with this request? ◯ Yes ◯ No
    a. **If yes, please submit an EPSDT Residential 1:1 Care request on www.magellanprovider.com separately from this request.**

6. Is there an Initial Plan of Care (IPOC) with all the required elements completed, signed, and dated as required (includes individual-specific long- and short-term goals, measurable objectives, interventions with timeframes, and family therapy as applicable)? ◯ Yes ◯ No
    a. If yes, was individual and their family/legal guardian included in the development of the IPOC? ◯ Yes ◯ No
    b. If yes, are individual-specific long- and short-term goals and measurable objectives aligned with Child and Adolescent Needs and Strengths Assessment (CANS) and Adverse Childhood Experiences Screening (ACES)? ◯ Yes ◯ No
    c. **Please attach a copy of the IPOC with this SRA.**

7. Is the individual treatment partially funded by CSA? ◯ Yes ◯ No
    a. What is the effective date of the reimbursement?

    b. **If yes to question 7, for both Psychiatric Residential Treatment Facility and Therapeutic Group Home, please attach the CSA Referral for Residential Treatment Services form; service cannot be authorized without the CSA Referral for Residential Treatment Services Form.**

Clinical

8. Please describe the individual's behaviors in the 30 days prior to admission that warrant this level of care. Please avoid using vague words such as 'aggressive' and include dates of behaviors, if known:

9. Please describe the individual's current (within the last 7 days) functioning, including current medications or recent changes to medications, and individual's ability to care for self and complete activities of daily living (ADL):

10. Is this individual currently at risk for seriously harming themselves or others? ◯ Yes ◯ No
    a. If yes, please describe the behaviors that put this individual at risk for harming themselves or others in detail including frequency, duration and severity of these symptoms. Please avoid using vague words such as 'aggressive':

    b. If yes, what is the safety plan?

11. What family individuals are involved or willing to be involved while this individual is in treatment?
    a. Are there barriers to them being involved in family engagement? ◯ Yes ◯ No
    b. If yes or if there are no family members involved, what steps are being taken to address the barriers?

12. Please describe the individual's current discharge plan (Please avoid simply stating where individual will live upon discharge.):

    a. What is the estimated discharge date?
    b. What is the expected discharge disposition? (i.e. home with parent, foster care home, Therapeutic Group Home)

    c. What are the recommended aftercare services for this individual?

    d. List the specific agencies to which the individual will be connected prior to leaving residential care?

e. What are the individual's natural support systems and/or community supports that will aid them in remaining in the community?

f. Identify barriers to discharge and how they will be addressed prior to discharge (this may include environmental and individual risk factors):

OUT-OF-STATE PROVIDER REQUIREMENT FORM

1. **Please select one of the four questions which best meets the reason you are requesting Out-of-State Provider Services and specify how the request meets the selected reason.**

   Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

   The medical services must be needed because of a medical emergency;

   a. *Is there documentation of a psychiatric/ behavioral health emergency?*

   Medical service must be needed and the Individual's health would be endangered if they were required to travel to their own state of residence;

   b. *Is there documentation that the individual's psychiatric/behavioral health condition will continue to decompensate if required to travel back to Virginia?*

   The state determines on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;

   c. *Based on a physician's advice, is the Psychiatric Residential Treatment Facility (PRTF) service more readily available in the other state? That is, what documentation is there that these services are not available in Virginia? Are there particular service needs that can only be addressed by this particular out of state provider? If so provide supporting documentation of all needs and the services to be provided.*

   It is the general practice from Individuals in a particular locality to use medical resources in another state

   d. *What locality is the individual a resident of?*

e. *Is it the general practice for individuals in this locality to use psychiatric/behavioral health resources out of state?* ◯ **Yes** ◯ **No**

f. *If yes, which state?*

g. *Is this a Department of Medial Assistance Services (DMAS) recognized "border state"?* ◯ **Yes** ◯ **No**
Enrollment of providers for Level C Residential Psychiatric Treatment for Children and Adolescents are generally limited to those located in Virginia or within 50 miles of the state line. KY, TN, NC, MD, and WV are all border states of Virginia.

h. *If the request is for a different state than noted in "c", why this state?*

Explain selected response:

2. Enrolled as a Provider with Magellan of Virginia? ◯ **Yes** ◯ **No**

Out of state provider may enroll with Magellan by going to: http://www.magellanofvirginia.com/for-providers-va/join-the-network.aspx

At the top of the page click on Provider Services and then Provider Enrollment in the drop down box. It may take up to 10 business days to become a Virginia participating provider.