Nebraska Medicaid Managed Care Program
Treatment Review & Authorization Request
Medicaid Rehab Option (MRO)

☐ Initial Authorization/Initial Clinical Assessment/POC
☐ Routine Request: (Up to 14 days)

☐ Re-Authorization/Plan of Care
☐ Urgent Request: (Within 72 hours) – Services are needed to stabilize the patient and prevent deterioration. Client needs significant and immediate supportive interventions.

Admission Date: _____ *Authorization Start Date_____ *Authorization End Date_____

Date of Request: _____

Managed Care Organization		
☐ **UnitedHealthcare Community Plan** Fax: 1-844-881-4926	☐ **Nebraska Total Care** Fax: 1-866-593-1955	☐ **WellCare** Fax: Outpatient Submissions: 1-855-279-3683 Inpatient Submissions: 1-877-849-5071
Provider(s) Information		
Program/Facility/Contact Person:	Phone #: Fax #:	Rendering Provider: NPI#:
Facility Information		
Name:	Medicaid Provider #:	NPI:
Member Information		
Name:	Date of Birth:	Nebraska Medicaid #:
Address:	Mobile Phone #: Home Phone #:	Additional Contact: Relationship: Phone #:
Current Diagnoses		
Psychiatric/Co-Occurring Substance Disorder (Code or Written Description): **Medical (Code or Written Description)**:		
Current Medications (medication name, dosage, frequency and prescriber): ☐ **None** ☐ **Yes, See Patient Med List**		
Justification for Authorization/Brief Explanation of Why Now (Please attach treatment history and current clinical documentation to support authorization request):		
Expectation for consumer's improvement on treatment plan goals:		
Discharge/Transition Plan: (See attachedTreatment Plan) Inpatient Admission in the last 90 days: ☐ None ☐ Yes		
Date of Last Assessment/Authorization: **Significant changes in member's life since last assessment:** ☐ Not applicable. This is an initial request for services ☐ No significant changes ☐ Changes noted as follows:		
Referral to Clinical Care Coordination: ☐Yes ☐Not applicable		

Overall Motivation to Treatment:

☐ Good – Willing to follow up with recommendations and actively participate in treatment

☐ Somewhat - Wants treatment, but sometimes forgets to complete action steps/plans or follow up with recommendations

☐ Poor – ☐Has or had difficulties following up with treatment because of poor insight

☐Not fully engaged or is ambivalent about the benefits of treatment

☐Denies having any problems and/or blames other for his/her problems

☐Other:

Family/Friends/Caregiver/Significant Other Involvement: ☐Active ☐ Limited ☐ None

☐ Not Applicable

Explain any less than active involvement:

Participation in Community Supports: ☐ Not at this time ☐ As follows:

Treatment Request

Treatment Request: please check service, units, frequency and weeks being requested.

☐**Assertive Community Treatmen**t: *Prior Authorization and Concurrent Request Required by All MCO's

1. Service Code being requested: H0040 or H0040-52 2. Number of Units: _____ 3. Frequency: _____(weeks)

☐**Psychosocial Rehabilitation Services (Day Rehab):** *UHCCP and NTC no prior auth required. Wellcare requires prior auth.

1. Service Code being requested: H2017 or H2018 2. Number of Units: _____ 3. Frequency: _____(weeks)

☐**Psychiatric Residential Rehab:** *Prior Authorization and Concurrent Request Required by All MCO's

1. Service Code being requested: H2018-TG 2. Number of Units: _____ 3. Frequency: _____(weeks)

☐**Community Support:** *UHCCP and NTC no prior auth required. Wellcare requires prior auth.

1. Service Code being requested: H2015-HE, H2015-HF 2. Number of Units: _____ 3. Frequency: _____(weeks)

Treatment Review
(Complete only when requesting Re-Authorizations)

Number of appointments attended since last authorization: _____

Type of Services and Units/Encounter used from last authorization:

☐ACT _____ # of Units ☐ Psych Res Rehab _____ # of Units ☐ PRS (Day Rehab) _____# of Units

☐Peer Support Services _____ # of Units ☐ Community Support Services _____# of Units

Treating Provider Signature:	**Date:**