



NEW HAMPSHIRE MEDICAID



SCHALLER ANDERSON
MEDICAL ADMINISTRATORS,
INCORPORATED

REQUEST FOR PRIOR AUTHORIZATION IN EXCESS OF SERVICE LIMITS PSYCHOTHERAPY SERVICES

*****PLEASE PRINT OR TYPE ALL INFORMATION*****

RECIPIENT NAME: _____ RECIPIENT MEDICAID ID #: _____
RECIPIENT DOB: ____/____/____

PROVIDER INFORMATION

PROVIDER NAME: _____ NH MEDICAID PROVIDER #: _____
ADDRESS: _____ CITY/STATE/ZIP: _____
TELEPHONE #: _____ FAX #: _____

CLINICAL INFORMATION

DIAGNOSIS (written) PRIMARY: _____
SECONDARY: _____
AXIS I: _____ AXIS II: _____ AXIS III: _____
AXIS IV: _____ AXIS V: _____

CURRENT MEDICATION

DOSE

FREQUENCY

<u>CURRENT MEDICATION</u>	<u>DOSE</u>	<u>FREQUENCY</u>

Has a prior authorization been requested on behalf of this recipient during this fiscal year? (7/1-6/30)

YES NO

If YES, Authorization #: _____

Is the recipient also covered under Medicare? YES NO

RECIPIENT HISTORY:

LEVEL OF FUNCTIONAL IMPAIRMENT:

WHY ARE THE SERVICES MEDICALLY NECESSARY?

TREATMENT PLAN (include time frames and progress information):

ARE THERE EXTENUATING CIRCUMSTANCES? IF YES, PLEASE ADVISE:

In the case of a child, is he/she coded? Yes No
 Does he/she have an IEP? Yes No
 Do you consult with the school regarding this child? Yes No
 Is the case open to DCYF or Division of Juvenile Justice? Yes No

If **YES**, document the name of contact or referral individuals: _____

SPECIFIC REQUEST ABOVE THE SERVICE LIMIT

Identify each service to be billed, provider name, and provider number. Each service must be identified with the number of sessions requested. (The start date is the 13th visit for psychotherapy services provided by ARNP's, pastoral counselors, social workers, and psychologists. The start date is the 19th visit for physicians/psychiatrists, i.e., psychiatrist and physician services are combined and count toward the physician service limit of 18 visits.)

PROVIDER	PROVIDER #	BILLING CODE	START DATE OF EXTENDED SERVICE	# OF SESSIONS REQUESTED	FREQUENCY PER MONTH

OTHER PROVIDERS

NAME	TITLE/LICENSE	AFFILIATION/SERVICE PROVIDED

CERTIFICATION OF MEDICAL NECESSITY

(to be signed by a physician, ARNP with a psychiatric/mental health specialty, or a psychotherapy provider licensed by the board of mental health practice)

I certify that the requested treatments and/or therapies are medically necessary and cost effective in obtaining measurable, realistic goals for the above-named recipient.

_____	_____
Signature	Date
_____	_____
Print	Specialty
Name/Title	

PLEASE FORWARD THIS INFORMATION TO SCHALLER ANDERSON BY FAX OR MAIL

Please submit supporting documentation for verification of above information.

Approval is a determination that the services requested are medically necessary and not a guarantee of payment.

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