of Tennessee

Psychiatric Residential Treatment Request Form (PRTF)

Please check line of business for this form:

- ☐ BlueAdvantage (PPO)SM
- ☐ BlueCare Plus (HMO SNP)SM
- ☐ CoverKids
- ☐ BlueCareSM
- ☐ TennCare *Select*

Request for inpatient residential level of care

Member number: _____

Member name: _____

Member date of birth: _____

Member contact number: _____

- Initial: ☐ Yes ☐ No
- Concurrent: ☐ Yes ☐ No
- If concurrent, please list auth number and fill out remainder of this section and then skip to concurrent review and treatment/discharge planning section towards bottom of form.
- Auth number: _____

Level of care being requested: inpatient psychiatric residential treatment

Provider name: _____

Provider phone: _____

Provider fax: _____

Place of service: inpatient psychiatric facility

Requesting clinician: _____

Requesting provider _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Treating provider: _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Requested facility: _____

Facility provider ID #: _____

Facility NPI #: _____

Facility address: _____

Psychiatric ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Medical ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Requested start date of service:_____

Units or number of days requesting: _____

Clinical Information Section

Describe in detail the patient's current condition to include…(thorough mental status, behavioral symptoms):

What attempts have been made to treat the patient with maximum intensity of services available at less intensive levels of care (especially within past 6 months)?

Fill out all that apply:

	Provider(s)	Frequency	Start date	End date	Comments
Medication management:					
Individual therapy:					
Comprehensive child and family treatment (CCFT):					
Family therapy:					
Continuous treatment team (CTT):					
Partial hospitalization program (PHP):					
Intensive outpatient program (IOP):					
Psychiatric acute hospitalizations:					
Applied behavioral analysis (ABA):					
Other community services:					
Child protective services:					
Arrests/legal charges:					
Substance abuse:					
School services:					

Why can the member not be treated in a lower level of care at this time?

Medications	Dose	Frequency	Dates	Outcome

Medication adherence? Barriers to adherence?

Does member have cognitive/intellectual impairment? ☐ Yes ☐ No
Please note details if applicable:

Describe patient's current family structure (living situation, parental roles, supervision/ structure, family strengths, areas needing improvement:

List the goals necessary and attainable for the patient/family within a residential treatment setting:

Are there any limitations for family participation in treatment (transportation, legal, etc)?
☐ Yes ☐ No (If yes, please provide details.)

Fill out this section only if patient is under the age of 18.

Who has custody of patient? _____

Is there any current CPS/DCS involvement? ☐ Yes ☐ No

Do any current symptoms/behaviors occur in school setting? ☐ Yes ☐ No

Is the school involved in current treatment plan? ☐ Yes ☐ No

Is the member involved with special education? ☐ Yes ☐ No

Fill out this section only if patient has eating disorder issues.

Patient height: _____

Patient weight:_____

% Ideal Body Weight (IBW): _____

Current BMI: _____

Orthostatic blood pressure: _____

Standing:_____

Sitting: _____

Pulse rate: _____

EKG, electrolytes, and other lab information:

Goal Weight/BMI _____

Last known episode of binging/purging/witholding:_____

Triggers for binging/purging/witholding:_____

Precipitant(s):

Fill out this section only if patient needs sexual offender related services.

Presenting problem:

What is current involvement with legal system and/or DCS?

When was the last time these behaviors occurred? _____

In what setting do these behaviors occur?

Is the school setting involved in current treatment plan? ☐ Yes ☐ No

Has a psychosexual assessment been completed prior to this request? ☐ Yes ☐ No
(If yes, please attach said assessment.)

Fill out this section for concurrent review only, then skip down to treatment and discharge planning section.

What progress has been made since the last review in regards to symptoms, behaviors, diagnosis, etc?

Current suicidal/homicidal ideations or psychosis present? ☐ Yes ☐ No

Medication changes: ☐ Yes ☐ No

Have there been any restraints or seclusions within the last authorization period?

(Please note dates/times as applicable.) ☐ Yes ☐ No
If no progress, how will the treatment plan be changed?

Family Involvement (phone, education, family sessions, visitations), please list details:

Treatment and Discharge Planning Section

What are the individualized attainable treatment plan goals and objectives for this level of care?

Are there any limitations for family participation in treatment (transportation, non-compliance, legal, etc.)?

☐ Yes ☐ No (If yes, please provide details.)

Discharge plan:

Anticipated barriers to discharge:

Primary Care Physician name and efforts to coordinate care:

Signature of ordering clinician including credentials (required to process):

_____

Date of signature:_____

Fax pre-certification numbers:

BlueAdvantage: 1-888-535-5243
BlueCare Plus: 1-866-325-6698
Bluecare/TennCare*Select*: 1-800-292-5311
CoverKids: 1-800-851-2491

Customer service numbers:

BlueAdvantage: 1-800-841-7434
BlueCare Plus: 1-800-299-1407
BlueCare: 1-800-468-9736
TennCare*Select*: 1-800-276-1978
CoverKids: 1-800-924-7141

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Behavioral Health Fax Form-
Psychiatric Residential Treatment