Peer Recovery Support Services Authorization Request

Member Name: _____ Member ID: _____ DOB: _____

Date of Request: _____ Intended/Actual Date of Initiation of Service: _____

Diagnosis (ICD-10): _____

Provider Name/Agency: _____ Phone: _____

Contact Name: _____ Address: _____

Tax ID: _____

PROVIDER REMINDER:

The Health Plan (THP) allows 180 units of PRSS service per month without an authorization. Claims that are filed for more than 180 units in the month will be denied if there is no authorization in the member file. The provider is referred to the complete policy on our website at healthplan.org, "For Providers" for further information.

In general, there are two reasons that additional units may be authorized to the end of the month. These are Initiation of Services after a Transition or Initiation of Services after a Critical Treatment Juncture.

Initiation of Services after a Transition:

Additional PRSS services may be authorized to the end of the current month for 30 days after discharge from a residential treatment, CSU, acute inpatient or correctional facility (including regional jail). The following information is required:

- Date of discharge from facility: _____
- Date of initiation of services: _____
- Name of facility/correctional setting: _____
- Diagnoses: _____
- Specification of additional units requested and period of time for which they are requested (may not exceed last day of month as next month allows 180 units without authorization):

  _____
- Description of activities that require the additional units (be specific)

  _____

  _____

  _____

  _____
- Attach copies of documentation from any prior PRSS services provided during the transition, if any.

- Is the member receiving any additional Medicaid services? If yes, please list.

  _____

  _____

Initiation of Services after a Critical Treatment Juncture:

Providers may obtain additional units of PRSS service to the end of the month if documentation supports the member's need for services:

- Describe critical treatment juncture: _____
- Describe member's reaction to the event: _____
- Date of event: _____
- Date of initiation of services: _____
- Number of units requested per day: _____
- Date span requested: _____
- Description of activities that require the additional units (be specific)

  _____

- Is the member receiving any additional Medicaid services? If yes, please list.

  _____

  _____

PLEASE ATTACH ANY CLINICAL EVIDENCE THAT SUPPORTS YOUR REQUEST AS WELL AS THE MEMBER'S CURRENT TREATMENT PLAN AND/OR PRSS TREATMENT STRATEGY.

Submit authorization/initiation of service requests to The Health Plan by phone or fax (1.866.616.6255).