



Prior Authorization Request Form

ICF / Respite / HDC

Provider Information			
Date Submitted:		Initial Request <input type="checkbox"/>	Concurrent Request <input type="checkbox"/>
Facility Provider:		Admitting Provider:	
NPI:		Medicaid ID:	
Tax ID (TIN):		Facility Address:	
Contact Name:		Phone Number:	
Fax Number:		Email address:	
Member Information			
Member Name:		DOB:	
CareSource ID:		Medicaid ID:	
ICD-10 Diagnosis Code(s)		Diagnosis Description:	
Type of Request			
Routine <input type="checkbox"/> Urgent <input type="checkbox"/> Retrospective <input type="checkbox"/>			
Intermediate Care Facility /HDC <input type="checkbox"/> <ul style="list-style-type: none"> ○ Authorization up to 6 months ○ Revenue Codes: 0183, 0185, 0189, 0194 		Respite <input type="checkbox"/> <ul style="list-style-type: none"> ○ Authorization up to 14 days; max of 90 days ○ Revenue Codes: 0660 	
Start Date:		End Date:	
Clinical Documentation (ICF and HDC)	<input type="checkbox"/> Psychological Testing + Adaptive function <input type="checkbox"/> Admission Assessment <input type="checkbox"/> Psychiatric Assessment <input type="checkbox"/> Medication List / MAR <input type="checkbox"/> Plan of Care with progress on goals <input type="checkbox"/> Positive Behavior Support Plan <input type="checkbox"/> History and Physical <input type="checkbox"/> Court orders <input type="checkbox"/> DHS 703/704	ICF Summary of Need documenting the individuals intense and complex care needs that make ICF the most appropriate level of care. Plans for discharge are required with every submission. HDC Summary of need describing why the primary caregiver needs respite, anticipated length of respite, and any clinical information to support how respite can prevent risk for decompensation.	

INSTRUCTIONS:

- 1.) All services should be reflected on the Person-Centered Service Plan (PCSP) and developed in collaboration between member, family/guardian, service providers and Care Coordination. Care Coordination assignment can be found in the Provider Portal or by emailing carecoordination@caresourcePASSE.com.
- 2.) The following are the current methods for submitting an authorization. Completed form is required.
 - a. Email: ServiceDeterminations@caresourcePASSE.com
 - b. Fax: 1-844-542-2605
 - c. [Provider Portal](#)

AR-PAS-P-2417204

Disclaimer: An authorization is not a guarantee of payment; Member must be eligible at time of services are rendered.

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