Prior Authorization Request Form

ICF / Respite / HDC

Provider Information			
Date Submitted:		**Initial Request ☐**	**Concurrent Request ☐**
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 ☐ Urgent ☐ Retrospective ☐			
Intermediate Care Facility /HDC ☐ ○ Authorization up to 6 months ○ Revenue Codes: 0183, 0185, 0189, 0194		**Respite ☐** ○ Authorization up to 14 days; max of 90 days ○ Revenue Codes: 0660	
Start Date:		**End Date:**	
Clinical Documentation **(ICF and HDC)**	☐Psychological Testing + Adaptive function ☐Admission Assessment ☐Psychiatric Assessment ☐Medication List / MAR ☐Plan of Care with progress on goals ☐Positive Behavior Support Plan ☐History and Physical ☐Court orders ☐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**

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