PrimeWest HEALTH™

Psychiatric Residential Treatment Facility (PRTF) Individual Plan of Care and Authorization

Request forms submitted with incomplete data cannot be reviewed and will be returned to your office.

Attach this completed form, along with other supporting documentation, to a medical Service Authorization request on the PRTF template. Service Authorization requests can be submitted in the PrimeWest Health Provider Web Portal. If you are not already registered for the Provider Web Portal, you can request access on our website at **www.primewest.org/requestaccess**.

Submission of this form does not guarantee approval.

If your facility has never billed PrimeWest Health, you will need to submit additional documents. These documents can be found on our website at **www.primewest.org/new-facility-claims.**

☐ Initial admission ☐ Change in insurance
☐ Updated plan of care ☐ Discharge notification
☐ Plan of care review for continued stay

PRTF Provider Information			
NAME OF FACILITY		NPI NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
CONTACT NAME	PHONE NUMBER	FAX NUMBER	
PHYSICIAN NAME		PHYSICIAN NPI NUMBER	
EMAIL ADDRESS			

Member Information				
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	PMI
DATE OF ADMISSION	ANTICIPATED DATE OF DISCHARGE (if known)			
PRIMARY DIAGNOSIS ☐ Check if change in diagnosis				
DESCRIPTION				
SECONDARY DIAGNOSIS				
DESCRIPTION				
ADDITIONAL DIAGNOSES REQUIRING TREATMENT OR SERVICES				
DESCRIPTION				
☐ Member has been assessed and meets criteria for certification of need for services in PRTF.				
PRIMARY INSURANCE COVERAGE	SECONDARY INSURANCE COVERAGE	PREVIOUS INSURANCE COVERAGE (if applicable)		

Presenting Symptoms Requiring PRTF Services
☐ Behavioral or psychiatric symptoms requiring treatment. Describe below.
☐ Severe, chronic, and frequent aggression or danger to self or others. Describe below.
☐ Functional impairment (unable to maintain behavioral control, frequent interpersonal conflict, and/or unable to appropriately engage in activities of daily living). Describe below.

Integrated Plan of Care		
ACTIVE TREATMENT	AMOUNT OR FREQUENCY	PROVIDER(S)
☐ Individual therapy		
☐ Family therapy		
☐ Group therapy		
☐ Other therapy (list below)		
OTHER ACTIVITIES	FREQUENCY	PROVIDER(S)
ARRANGED SERVICES	FREQUENCY	PROVIDER(S)
☐ Rehab (OT, PT, speech)		
☐ Psychological testing		
☐ Neuropsychological testing		
☐ Other therapy (list below)		
OTHER ARRANGED SERVICES NOT PROVIDED AT THE FACILITY (MEDICAL, DENTAL, ETC.)		
☐ PRTF will arrange for all necessary medical and dental care while member is admitted to the facility.		

Comprehensive Discharge Planning – Coordination with Community-Based Providers		
PROVIDER	SERVICE TYPE	FREQUENCY
THERAPEUTIC LEAVE DAYS PLANNED	DATE(S)	TOTAL NUMBER OF DAYS

Concurrent Services (service provided by community-based provider for purpose of discharge)		
PROVIDER	SERVICE	FREQUENCY
Alternative placement arrangement upon discharge (other than home). ☐ YES ☐ NO		
If yes, describe plans for placement and responsible person or agency.		

Attachments

☐ Diagnostic assessment (current within the past 180 days)
☐ Individual treatment plan (ITP) containing specific treatment goals
☐ Updated ITP (if possible)
☐ Weekly progress report(s) (last 30 days)
☐ Current risk or safety assessment

Recertification Only

Attestation that the PRTF provided the following required services included in the initial plan of care (PoC):
☐ Individual therapy: a minimum of two out of every seven days
☐ Family engagement activities: a minimum of one out of every seven days
☐ Group therapy as indicated in the PoC
☐ Other professional services under arrangement as identified in the PoC
☐ Discharge planning and consultation with other professionals, including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners

DATE OF PHYSICIAN SIGNATURE ON COMPLETED POC OR ITP.

PROVIDER SIGNATURE	DATE