

Administrative Prior Authorization Form

Providers must complete this Administrative Prior Authorization Form and submit to the managed care organization (MCO) that the beneficiary is enrolled with. The provider must receive authorization response from the MCO prior to beginning services to avoid claims denial. Please see the detailed descriptions/directions at the end of this form for information to assist in completion of each data element.

Kentucky Medicaid Recovery Residence Support Services (RRSS) Administrative Prior Authorization Form

- ☐ Initial Notification
 - ☐ Initial request for RRSS
 - ☐ Enrollee change of MCO or transition from fee-for-service (FFS) to MCO
- ☐ Completion Notification (See Program Completion Section)
 - ☐ Recovery goals are met
 - ☐ Administrative dismissal
 - ☐ Voluntary dismissal
 - ☐ Exhausted 90-day limit

Member Information

3. Managed Care Organization *(Check the box for the MCO that the member is enrolled)*

- ☐ Aetna Better Health of Kentucky
- ☐ Humana Healthy Horizons in Kentucky
- ☐ Passport Health Plan by Molina
- ☐ UnitedHealthcare Community Plan
- ☐ WellCare of Kentucky

4. Prior Authorization Type: *TC-Transitional Care*

5. Date of Request (*mm/dd/yyyy*)

6. Member Name *(First, Middle Initial, Last)*

7. Date of Birth (*mm/dd/yyyy*)

8. Member Medicaid ID #

9. Member MCO ID #

10. Member Contact Information

Provider Information

11. Recovery Residence Program Name

12. Recovery Residence Physical Address (*Street, City, State, Zip Code*)

13. Requesting Provider Name

14. Provider National Provider Identifier (NPI) #

15. Provider Tax ID #

16. Fax #

17. Residence Point of Contact (POC)

18. POC Phone #

Type of Service Requested (Check One)

19. Type of Service Level

☐ NARR Level 2

☐ NARR Level 3

20. Number of Days Requested:

OR

20a. Number of Days Requested from New MCO (following beneficiary transfer to a new MCO)

Former MCO:

New MCO:

Number of Days Utilized:

Number of Days Requested:

21. Requested Start Date (*mm/dd/yyyy*)

Additional Supporting Documentation

22. Additional Supporting Documents

Eligibility Requirements

☐ At least 18 years of age

☐ Have active Medicaid coverage

☐ Have a substance use disorder (SUD) diagnosis

SUD Diagnosis Code: Click or tap here to enter text.

The following supporting documentation is required with the SUD Diagnosis Code:

For Reentry 1115 participants, providers may include a clinical behavioral health assessment or qualified mental health professional attestation.

For Behavioral Health Conditional Dismissal Program (BHCDP) participants, include the "Findings from Initial Assessor" form.

☐ Must not reside in a residential level of care of 3.1 or higher (meet American Society of Addiction Medicine Level of Care 2.7 or less)

☐ Participating in BHCDP

(For BHCDP participants, include the "Findings from Initial Assessor" form.)

OR

☐ Have received pre-release services under the Reentry 1115 Demonstration

☐ In addition to a history of criminal involvement, does the member have a history or currently experiencing any of the following social stability indicators:

☐ Experiencing homelessness

☐ Unemployment

☐ Current environment threatens beneficiary safety or well-being, and they require, at a minimum, safe housing with appropriate support to safely participate in outpatient treatment

23. Additional Information: Would this member benefit from additional support services?

Program Completion

(This section is to be completed only when the member is no longer participating)

24. Completion Date (mm/dd/yyyy)

25. Total Number of Authorized Days Utilized

26. Post Completion Destination (if applicable)

27. Additional Services Provided

- | | | |
|---|---|---|
| ☐ Recovery Support Class | ☐ Peer Support Meetings | ☐ Family Support Services |
| ☐ Life Skills Training | ☐ Supporting Career Training and Education | ☐ Recovery Management Skills |
| ☐ Individual Recovery | ☐ Coordinating Legal Services | ☐ Other (List additional services) |
| ☐ Coaching | ☐ Employment Support Services | |
| ☐ Community/House Meetings | | |
| ☐ Mutual Aid Groups | | |

28. Completed by:

29. Phone #

MCO Review
(This section will be completed by the members' MCO)

Prior Authorization Type: TC- Transitional Care

PA Control #:

Record Identifier #:

Authorization Indicator:

Creation Date:

Received Date:

Header Status:

Effective Date:

End Date: