Phone (602) 263-3000 Toll Free (800) 624-3879 Fax: 1-855-825-3165

Child and Adolescent 45 Day Clinical Review for Continued Prior Authorization of Residential Facility

(FAX completed form to: Mercy Care RBHA Utilization Management at 1-855-825-3165
Failure to submit update within 4 days will result in denial of Prior Authorization

Demographic Information	
C/A Name:	Case Manager:
Fax:	PNO/QSP:
Date this C/A was previously approved for Residential Treatment:	Level of care previously approve:

The following information is needed to confirm that this Level of Care is still medically necessary because this C/A has not been admitted within 45 days from the date of approval. Please submit this information **via Fax.** You will be notified of this C/A's Level of Care Determination.
PLEASE ATTACH:
Current **psychiatric progress note and any service provider notes since previous approval.**

Current Psychiatric Symptoms/Behaviors
Date of Last Psychiatric Visit:
Specify any current services that are now being utilized:
Natural Supports currently in place to maintain the C/A in the community:
Why does the C/A still require this Level of Care? (Describe behaviors /symptoms that continue to fail community based services)