



Phone (602) 263-3000  
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## Child and Adolescent 60 Day Clinical Review for Continued Prior Authorization of HCTC

**(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 60 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)