

Re-Certification of Need (RON) for Inpatient Facilities

For persons 21 years of age or older a RON must be completed at least every 60 days.
For persons under the age of 21 the treatment plan must be completed and reviewed every 30 days. The completion and review of the treatment plan meets the requirement for the re-certification of need.

Date of Admission: _____ Date RON Due: _____
Date of RON: _____ Time: _____ AM PM

Client Information:

Name: _____ Date of Birth: _____

Address: _____

AHCCCS Number: _____ Social Security Number: _____

Medical Provider: _____ Provider Phone #: _____

DSM or ICD Diagnostic Codes:

Axis I: _____ Axis II: _____ Axis III: _____ AXIS IV: _____ AXIS V: _____

- Please indicate why proper treatment of the person's behavioral health condition continues to require services on an inpatient basis under the direction of a physician.
- Please indicate why the requested service can reasonably be expected to improve the person's condition or prevent further regression so this level of service will no longer be needed.
- Please indicate why outpatient resources available in the community do not meet the treatment needs of this person.

I am aware of the client's condition and have been provided sufficient information to determine this level of care is appropriate.

Physician's Signature: _____ Dated: _____

Print Name: _____

Placement: _____

Inpatient Facility Provider Name: _____

Requested Service Dates: From: _____ To: _____ Discharge: _____

Providers - completed RON must be faxed to **Mercy Care RBHA** at **855.825.3165**