

MEMBER NAME

AHCCCS ID#

REQUEST/NOTIFICATION TYPE

RENEWAL AUTHORIZATION DATES OF AUTHORIZATION: _____

IF DATES ARE DIFFERENT FROM PREVIOUS AUTHORIZATION,
STATE THE REASON FOR THE DATE RANGE CHANGE:

PLACEMENT CHANGE EFFECTIVE DATE: _____
REASON: _____

TERMINATION EFFECTIVE DATE: _____
REASON: _____

CONTRACTOR CHANGE NEW CONTRACTOR: _____
EFFECTIVE DATE: _____

RE-APPROVAL OF BEHAVIORAL HEALTH REINSURANCE REASON: _____

PRINTED NAME OF AUTHORIZED REPRESENTATIVE

TITLE

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

CONTRACTOR

MEMBER NAME

AHCCCS ID#

MEMBER DEMOGRAPHIC INFORMATION

MEMBER DATE OF BIRTH

FACILITY NAME AND TYPE:

PLACEMENT DATE:

DAILY RATE:

PURPOSE OF FORM

The purpose of this Form is to evaluate a member's continued eligibility for High Cost Behavioral Health Reinsurance. This Reinsurance was discontinued effective October 1, 2007. However, members who had been approved and active prior to this date may continue to be approved for this Reinsurance subject to periodic re-evaluation. The Reinsurance is for individuals who have significant behavioral problems or a history of behaviors which have been documented as difficult to manage, require a specialized service regimen for the management of behavioral challenges, and would be inappropriate for placement in a locked Alzheimer's or dementia unit.

Provide the below information, which will be used to evaluate whether the member continues to meet the qualifying criteria for High Cost Behavioral Health Reinsurance.

DIAGNOSES

INCLUDE BEHAVIORAL AND PHYSICAL, AS RELEVANT:

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CURRENT BEHAVIORAL ISSUES

Describe member's current behaviors and the frequency and intensity of those behaviors, including an explanation regarding any barriers managing the challenging behaviors.

NOTE: It is essential that these behaviors are current and related to specific diagnoses and demonstrate the member's need for additional staffing or specialized care being supported by the BH Reinsurance program.

FACILITY PROGRAMMING DESCRIPTION

Explain programs and activities at the facility specific to this member that assist this member in managing inappropriate behaviors.

NOTE: These are the staffing or service elements for which this member needs the supplemental funding of the BH Reinsurance program.

BEHAVIORAL TREATMENT/SERVICE PLAN

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Explain/describe behavioral and chemical interventions in place to actively manage member's current behavioral issues, including any specialized services needed to manage the member's behavioral challenges.

NOTE: These interventions shall be supported by the attachment of relevant documentation.

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PLACEMENT HISTORY

Explain why this member cannot live in a less restrictive living arrangement and include specific information (including dates) regarding reason(s) previous placement(s) were unsuccessful.

RE-EVALUATION OF PLACEMENT

Provide results of periodic re-evaluation of the member's ability to function with a lower level of intervention than provided under the current treatment plan (not just attempts at placement change).

Explain any discharge plans, if applicable.

NOTE: Documentation is required to be attached that both demonstrates periodic re-evaluation and the need for continuation in the current placement.

DOCUMENTATION SHALL INCLUDE

- Behavioral Treatment/Service Plan.
- Psychotropic Medication Record.
- Psychiatric or psychological evaluation reports.
- Nursing notes with behavioral issues highlighted.
- Facility staff shift notes with behavioral issues highlighted.
- Any other information in the member's records that supports the member's significant behavioral challenges and the need for a specialized service regimen due to the member's behavioral issues.

NOTE: Documentation shall demonstrate current behavioral issues and associated interventions identified in the Behavioral Treatment/Service Plan section.

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TITLE

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

CONTRACTOR

NAME, PHONE NUMBER, AND EMAIL ADDRESS OF THE INDIVIDUAL TO BE CONTACTED BY AHCCCS IF THERE ARE QUESTIONS REGARDING THE CONTENT ENTERED ON THIS OR THE ACCOMPANYING DOCUMENTATION:

NAME: _____

Phone: _____ Email: _____