Residential Treatment Center (RTC) Request Form

This form must be completed electronically, printed and faxed. No handwritten forms will be accepted. Please fax the completed form to 570-214-4539. If you have questions regarding this form, please call 888-839-7972.

Date of request: **Member's name:**

Date of birth: **Member's Health Plan ID:**

Requesting physician's name:

Requesting physician's NPI:

Referring physician's name:

Address:

Contact name: Contact phone: Ext.:

Fax:

Facility:

Contact name: Contact phone: Ext.:

Fax:

Recommended documentation

Provide the following clinical documentation to assist in determining medical necessity for benefit reimbursement:

- Current psychiatrist's psychiatric evaluation (within 30 days of the request)
- Detailed psychosocial history
- If currently hospitalized, include the family therapy, individual therapy and doctor's progress notes for the current stay and indication of the outpatient provider support of RTC
- Clinical information from previous inpatient psychiatric/substance use admissions
- If outpatient, include a letter from each outpatient provider summarizing the intensity of treatment over the past six months and why treatment is failing, or a copy of the treatment records for the past eight visits

Diagnostic and Statistical Manual (DSM) diagnosis:

Is there cognitive/intellectual impairment?

☐ No ☐ Yes

If yes, attach copies of psychological tests and describe here.

Facility is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, halfway house, sober living residence, wilderness camp or any other facility that provides custodial care.

Are there any significant physical or medical problems?

☐ No ☐ Yes

If yes, describe here.

Describe the member's current condition in detail, including mental status and behavioral symptoms, which would indicate residential treatment may be necessary.

List reasons why the member cannot be treated at a lower level of care.

What attempts have been made to treat the patient with the maximum intensity of services available at a less intensive level of care, especially within the past six months?

Treatment/involvement	**Provider(s)**	**Frequency**	**Start/end dates**	**Comments**
Individual therapy				
Family therapy				
Partial hospital				
Psychiatric medication management				
Psychiatric/substance use hospitalization (last three years)				
Community services				
Child protective services				
Arrests/legal charges				
School services				
Military agencies				
Case management				
Intensive outpatient				

Current psychiatric medications	**Dose/frequency**

Past psychiatric medication trials	Start/end date	Results/reason for discontinuation

Substance type	Amount/frequency	Duration	Age started	Last use	Treatment	Outcome/results

Describe member's current family structure and support system (living situation, parental roles, family strengths, areas needing improvement):

List the goals necessary and attainable for the member/family within a residential treatment setting (treatment duration may be several months):

1.
2.
3.

If family involvement is therapeutically contraindicated, please explain:

Are any barriers anticipated to the member's reunification back into the family home after discharge from RTC?

Family therapy requirements for age 18 and younger:

The custodial parent/family is required to participate in weekly, on-site family therapy. If due to hardship, parents are unable to attend therapy on-site, weekly family therapy must occur, with appropriate documentation, using remote technology-assisted applications.

This requirement was discussed with the custodial parent, they understand and agree to participate.

☐ No ☐ Yes