MOLINA HEALTHCARE | Molina Complete Care

Out-of-home placement for behavioral health treatment checklist

Please complete the out-of-state placement checklist, Molina Complete Care prior authorization form and all supporting documentation for medical necessity review. Please fax all documentation to our utilization management team at (888) 656-7501.

Requested level of care: ☐ BHIF – rev. code 0124 ☐ BHRF – H0018

Member name: _____ **Member AHCCCS ID:** _____ **Member date of birth:** _____

BH provider name: _____ **BH provider phone number:** _____ **Agency:** _____

Care manager name: _____ **Care manager phone number:** _____

Legal guardian name: _____

Legal guardian's relationship to member:

☐Biological ☐Adoptive ☐Foster ☐Kinship ☐ DCS

DCS worker's name: _____ **DCS worker's phone number:** _____

Probation officer's name: _____ **Probation officer's phone number:** _____

Physical care provider's name: _____ **Physical care provider's phone number:** _____

Member's current location: _____ **Length of time member has been at this location:** _____

Please attach the following documents (any missing documentation will delay the processing of this request):

- Current medication list
- Latest psychiatric evaluation
- Treatment plan
- Last six months of psychiatric progress notes
- Last three CFT meeting notes
- Any/all psychological, neurological or psychosexual testing (if applicable)
- IEP or 504 from school
- Other service agency's progress notes

Diagnosis (physical and behavioral health):

_____

Reason for placement (check all that are applicable):

☐ Self-harming behavior
☐ Substance use
☐ Sexual maladaptive behavior
☐ Aggressive behavior
☐ Other behavior (please describe): _____

Current services utilized within the last six months: _____

Type of service: _____

Reason for service: _____

Outcome/progress: _____

Facility or facilities that have declined to accept the member (minimum of three in-state facilities before going out of state): _____

Name of facility: _____

Date declined: _____

Reason for declining: _____

Expected improvements from placement: _____

Tentative discharge plan: _____

Date(s) of service: _____