INSTRUCTIONS FOR FORM PCF05:
PSYCHIATRIC/SUBSTANCE ABUSE EXTENSION OR RECONSIDERATION

NOTE: Fields 1 – 6 MUST be filled in

Any incomplete form WILL BE REJECTED

1. Enter the assigned Pre-Certification Case Number if this is a request other than an initial.

2. Enter the 13-digit recipient Medicaid identification number.

3. Enter the recipient's last name, first name, and middle initial.

4. Enter the seven-digit hospital Medicaid number.

5. Enter the admitting and primary (if applicable) ICD-9-CM diagnoses codes if this is an initial request. If this is an extension request, enter the extension ICD-9-CM diagnosis code. **Either an admitting or an extension diagnosis code is required. Also, the description of the diagnosis is required.**

6. Check in the appropriate box the type of request: psychiatric or substance abuse, extension or reconsideration.

7 – 15. Use these fields to complete pertinent medical information regarding the recipient for an admission request. If additional information is necessary, up to two pages may be submitted.

16 – 23. Use these fields to complete pertinent medical information regarding the recipient for an extension request. If additional information is necessary, up to two pages may be submitted.

24. **An authorized signature is required. Requests will not be accepted if not signed.**

25. Enter the date this request is submitted to Molina.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

Please Print or Type

PRE-CERT CASE # (1)

RECIPIENT ID NUMBER (2)	RECIPIENT LAST NAME (3) FIRST MI	PROVIDER NUMBER (4)

ICD-9-CM ADMISSION/EXTENSION DIAGNOSIS AND DESCRIPTION (5)

REQUEST TYPE (6)

- PSYCHIATRIC ☐
- SUBSTANCE ABUSE ☐
- EXTENSION ☐
- RECONSIDERATION ☐

INSTRUCTIONS: When providing supporting documentation, *mark areas specific to topics addressed.*

ADMISSION CRITERIA

1) Presenting problem and course of illness: _____

(7) When did it start: _____
(Provide supporting medical documentation)

2) Presence of suicidal/homicidal ideations, intent, plan, and/or attempt, if any. (Describe in detail with *dates*, and provide supporting medical documentation).

(8)

3) Can patient or family care for himself/herself? If not, describe specifics. (Provide supporting medical documentation.)

(9)

4) Presence of sleep and/or appetite disturbances, if any, and indicate onset of each or both if present. (Provide supporting medical documentation.)

(10)

5) Presence of psychosis, if any, *with date of onset.* Describe specific hallucinations, behavior aberration, and present treatments – OPD and Hospital. (Provide supporting medical documentation.)

(11)

6) Presence of intoxication with substance abuse requiring detoxification. Specify substance(s): _____
How long used (for each substance)? Provide supporting medical information about the amount used and frequency for each substance specified. Also provide date of *last use for each substance specified.*

(12)

7) Presence of major mood disorders with vegetative symptoms or delusions? For how long?

(13)

8) Previous psychiatric hospitalization and/or substance abuse treatment. List each hospitalization with *dates*, and specify inpatient or outpatient.

(14)

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

PRE-CERT CASE #

9) Does patient have history of withdrawal symptoms or complications? If yes, describe when and give specifics.

(15)

EXTENSION CRITERIA

Please use space to answer and provide documentation to the eight extension criteria issues.

1) Treatment plan goals.

(16)

2) Methods used to address treatment plan goals.

(17)

3) Course of hospitalization, to date.

(18)

4) Patient's level of functioning on unit.

(19)

5) Presence of special precautions.

(20)

6) Is behavior on unit dangerous? Compliant?

(21)

7) Have medication dosages been changed recently?

(22)

8) How would further hospitalization benefit this patient?

(23)

PROVIDER SIGNATURE: (24) _____ **DATE:** (25) _____

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

Please Print or Type

PRE-CERT CASE #

RECIPIENT ID NUMBER	RECIPIENT LAST NAME	FIRST	MI	PROVIDER NUMBER

ICD-9-CM ADMISSION/EXTENSION DIAGNOSIS AND DESCRIPTION	REQUEST TYPE	
	PSYCHIATRIC ☐	EXTENSION ☐
	SUBSTANCE ABUSE ☐	RECONSIDERATION ☐

INSTRUCTIONS: When providing supporting documentation, *mark areas specific to topics addressed.*

ADMISSION CRITERIA

10) Presenting problem and course of illness: _____

When did it start: _____
(Provide supporting medical documentation)

11) Presence of suicidal/homicidal ideations, intent, plan, and/or attempt, if any. (Describe in detail with *dates*, and provide supporting medical documentation).

12) Can patient or family care for himself/herself? If not, describe specifics. (Provide supporting medical documentation.)

13) Presence of sleep and/or appetite disturbances, if any, and indicate onset of each or both if present. (Provide supporting medical documentation.)

14) Presence of psychosis, if any, *with date of onset*. Describe specific hallucinations, behavior aberration, and present treatments – OPD and Hospital. (Provide supporting medical documentation.)

15) Presence of intoxication with substance abuse requiring detoxification. Specify substance(s): _____
How long used (for each substance)? Provide supporting medical information about the amount used and frequency for each substance specified. Also provide date of *last use for each substance specified.*

16) Presence of major mood disorders with vegetative symptoms or delusions? For how long?

17) Previous psychiatric hospitalization and/or substance abuse treatment. List each hospitalization with *dates*, and specify inpatient or outpatient.

STATE OF LOUISIANA DHH – BHSF
MEDICAL ASSISTANCE PROGRAM
Request for Psychiatric/Substance Abuse Extension/Reconsideration

PRE-CERT CASE #

18) Does patient have history of withdrawal symptoms or complications? If yes, describe when and give specifics.

EXTENSION CRITERIA

Please use space to answer and provide documentation to the eight extension criteria issues.

9) Treatment plan goals.

10) Methods used to address treatment plan goals.

11) Course of hospitalization, to date.

12) Patient's level of functioning on unit.

13) Presence of special precautions.

14) Is behavior on unit dangerous? Compliant?

15) Have medication dosages been changed recently?

16) How would further hospitalization benefit this patient?

PROVIDER SIGNATURE: _____ **DATE:** _____