

08-2022

## Addiction and recovery services extension requests

This reauthorization is for Hennepin Health only. Instructions below.
Fax completed form to 612-466-9546

|  |
| --- |
| Client information  |
| Name:  | Social security #:  | Date of Birth: |
| PMI (if available): | Chemical health provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Admission date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Admission dimensions ratingsDimension 1. \_\_\_ 2.\_\_\_ 3.\_\_\_ 4. \_\_\_ 5. \_\_\_ 6. \_\_\_ | Current dimensions ratingsDimension 1. \_\_\_ 2.\_\_\_ 3.\_\_\_ 4. \_\_\_ 5. \_\_\_ 6. \_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| Dates of new services | Number of days/hours requested | Additional number of days used | Modifiers (circle)\* |
|  |  |  | HH U4 HA U8 TGTF UD U6 U5 UC HK |

\*See [modifier code descriptions](#_Modifiers:) on pg. 3

Please explain below why client needs more time and specific clinical services provider will offer. Include:

1. Most recent progress notes

2. Updated treatment plan

3. Addendum, if needed

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor requesting extension (Print) Date of request Counselor phone number

### Service start date/end date changes

Current SA: Line 1: Start Date\_\_\_\_\_\_\_\_\_ End Date\_\_\_\_\_\_\_\_\_ # Units\_\_\_\_\_\_\_\_\_

 Line 2: Start Date\_\_\_\_\_\_\_\_\_ End Date\_\_\_\_\_\_\_\_\_ # Units\_\_\_\_\_\_\_\_\_

Additional SA: Line 1: Start Date\_\_\_\_\_\_\_\_\_ End Date\_\_\_\_\_\_\_\_\_ # Units\_\_\_\_\_\_\_\_\_

 Line 2: Start Date\_\_\_\_\_\_\_\_\_ End Date\_\_\_\_\_\_\_\_\_ #Units\_\_\_\_\_\_\_\_\_

### Approval/Denial

\_\_\_ Reauthorization approved \_\_\_ Reauthorization denied

Explanation (if denied):

Placing Authority Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Directions for reauthorization request

If you are requesting client move to another level of care (i.e. OP) in your facility or move to another program, do not use the extension request form. Instead, follow the instructions [here](#_Program_or_level).

This form must be completely filled out.

### Client information:

* Client legal name/alias
* Date of birth
* Social security number
* PMI if available

### Chemical health provider:

* Name of program
* Telephone number of counselor making request or other contact number

Admission date:

* The date the client started the program

Dimension rating:

* Admission and current ratings
* Attached progress notes should clearly reflect the reason(s) for the current ratings. Refer to risk dimensions/placement decision forms when determining the risk factors and placement needs within your program. Include any Mental Health diagnoses and documentation from external or internal MH providers.

Services requested:

* Projected client discharge date
* Number of days (residential) or hours (outpatient) the client has completed
* Additional number of hours or days requested

### Modifiers:

* Any modifiers that may apply to the client
* Code descriptions:
	+ *HH: Co-occurring*
	+ *U4: Special Populations*
	+ *HA: Adolescent*
	+ *TG: Residential, High*
	+ *TF: Residential, Medium*
	+ *UD: Residential, Low*
	+ *U6: Client w/Child*
	+ *U5 Medical Svc*
	+ *UC: Co-occurring + Med. Svc.*
	+ *U8: MAT Dosing, Residential Methadone*
	+ *U9: MAT Dosing, Residential other drug*
	+ *HK: commitment rate*

### Narrative area

* Explain why the client needs more time.
* Explain what the provider is going to do to assist the client with their goals.
* Attach an addendum to the form if you need more space than provided to explain the reasons in full. This addendum can be legibly handwritten or typed.

## Program or level of care change

1. Complete an update/referral load document
2. Provide a filled out signed CPA form
3. Provide a completed placement summary

### How to submit the above forms

1. Fax requests along with a completed CPA for any changes to 612-466-9546.
2. Fax all requests for Drug Court and DWI Court clients to embedded social workers.
	1. Drug court fax 612-7665853
	2. DWI court fax 612-466-6803