Mailing Address:
P.O. Box 1309
Minneapolis, MN 55440-1309
Mailstop 21103M

Child and Adolescent Psychiatric Residential Treatment Program

Concurrent Review: Request for Continuing Insurance Coverage

Behavioral Health Department	Phone number: 1-866-669-3856	Fax number: (952) 853-8830

Please answer ALL of the following questions.
This information is REQUIRED to determine medical criteria are met for continuing insurance coverage.

PERSON REQUESTING AUTHORIZATION OF COVERAGE

Name:	
Clinic Phone #:	**Fax #**:

MEMBER INFORMATION

Member Name:	**CoOportunity Health ID #**:	**DOB**:
Current Symptoms: **School Issues:** **Therapeutic Passes** (Dates, goals, progress parental feedback) **Psych Testing Results** (if applicable):		

SPECIFIC PROGRESS SINCE LAST REVIEW

CoOportunity Health has contracted with HealthPartners Administrators, Inc to provide claims processing, medical management and certain other administrative services.

INDIVIDUALIZED TREATMENT PLAN GOALS

Treatment Goals	Evidence of Progress Toward Goal

DATES OF EVALUATION/TREATMENT WITH PSYCHIATRIST SINCE LAST REVIEW

Required not less than once per month for coverage for residential tmt. Please send copy of most recent psychiatric note.	
List all medications used with dose and frequency.	**Note dates of new medications started and discontinued.**

DATES OF TREATMENT WITH FAMILY/SUPPORTIVE OTHER SINCE LAST REVIEW

Family Therapy is required not less than once per week for coverage for residential treatment.	
List date of family therapy session and attendees	**Family Therapy Goals / progress toward these goals**
1.	
2.	
3.	
4.	

DISCHARGE PLAN

List names for continued care/support upon discharge	List phone # and date of appointment
Individual Therapy:	
Family Therapy:	
Medication Management:	
Other Treatment or Support:	
School:	
Living Environment:	
County Social Worker:	
Signature of Requesting MH Professional: **Date**:	
Fax completed form to Behavioral Health: (952) 853-8830	
To be completed by Behavioral Health department only: All requested documents have been provided ____Yes ____No Parent(s) or significant other agrees to participate in case management services. ____Yes ____No Parent(s) or significant other agrees to participate in family therapy services. ____Yes ____No	