

Idaho Psychosocial Rehabilitation Services Service Plan Authorization

(PSR Providers: Please complete all items in this box.)

Provider/Region: _____ Participant Name: _____
 Provider #: _____ MID #: _____
 Agency Phone: _____ Agency Fax: _____

MEDICAID MENTAL HEALTH PA UNIT USE ONLY

IPA Start Date: _____ PA #: _____
 Service Plan Start Date: _____ End Date: _____

DESCRIPTION:	Individual PSR	Group PSR	Collateral Contact <i>(Modifiers)</i> <i>Telephone HE</i>	Pharm. Mgmt.	Psychotherapy Ind.: 90804 <input type="checkbox"/> 90806 <input type="checkbox"/> 90808 <input type="checkbox"/> Family: 90847 <input type="checkbox"/> Group: 90853 <input type="checkbox"/>	Nursing Services	Other	Other
CODE:	H2017	H2014	90887	90862		T1001		
TOTAL APPROVED UNITS PER:				Occurrence				

Plan is approved as submitted.

Plan is approved with following modifications:

Units reduced from _____ to _____ in: RHIP-H2017 RHCC-90887 RHGP-H2014

Reason for reduced hours: _____

MMHPA Reviewer: _____ Date: _____

Note: Please modify the plan as noted and **keep it in the front of the participant's file.**