Psychiatric Rehabilitation Services Adult- Precertification

(To be Completed After Conducting An Assessment)

Date: _____

Consumer Name: _____ DOB: _____ MA ID#: _____

Provider: Contact Name _____ Provider: Contact Phone #_____

Requested Services: On-site _____ Off-site _____ Blended_____

Requested Start Date for this Authorization: _____

Reason for Referral: As a result of the consumer's mental health concerns, please detail the current level of functional impairment that interferes with or limits performance in one of the following domains: living, learning, working or socialization:

_____

_____

Skills the consumer requested to support his/ her recovery: _____

_____

Skills to be addressed within the first Individuals Recovery Plan: _____

_____

Support Systems (Natural and Community)? _____

******Please remember to upload the completed Referral Form******