Medical Necessity Form – LPHA Recommendation for Children & Family Treatment & Support Services

Instructions: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (Individual currently licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Masters Social Work, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Licensed Creative Arts Therapist, or Physician).

Recommendation for Rehabilitative Service(s):

Participant Name:	Date of Birth:
Parent/Caregiver:	Relationship:
Address:	Phone:
County of Residence:	Medicaid CIN #:

Behavioral Health Information: *Check all that apply:*

List	**Diagnosis Category**	**Specific Diagnosis or Symptoms of Mental Illness (MH)/Substance Use (SUD)**	**DX Code**
Primary			
Secondary			
Other			

Areas of Functioning: (As a result of the symptoms or diagnosis of MH/SUD, the child/youth has a functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.) *Check all that apply:*

Check	**Domain**	**Description of Impairment**
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended Child and Family Treatment and Support Service(s): *Check all that apply:*

Check	Rehabilitative Service	Description of Needed Intervention (if known/applicable)
	Other Licensed Practitioner (assessments, treatment planning, crisis prevention planning, psychotherapy/counseling	
	Community Psychiatric Supports and Treatment (Intensive counseling)	
	Psychosocial Rehabilitation (Skill development and building)	
	Family Peer Support Services (self-advocacy, building community connections and natural supports, parent skill development)	
	Youth Peer Support and Training (skill building, building community connections and natural supports, self-advocacy, transition to adulthood support and skill development)	

Reason for recommendation:

_____
_____
_____
_____

**By signing below, I am recommending the above-named individual for Child and Family Treatment and Support Service(s)*

_____ _____ _____ _____

**LPHA Signature Printed Name NPI# Date