Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
Fax: 803-714-6456
www.CompanionBenefitAlternatives.com

Residential Treatment Center (RTC) Request Form

Please complete all parts as **clearly** and as **specifically** as possible.
Omissions, generalities and illegibility will result in us returning the form for completion or clarification.
We will not consider it a complete request.

Patient's Name: _____
Patient's ID # (with alpha prefix): _____ Date of Birth: _____
Requesting Physician's Name: _____ Physician's NPI #: _____
Referring Physician's Name: _____ Date of Request: _____
Referring Physician's Address: _____
Address Where You Render Services: _____
Requesting Begin Date of Certification: _____
Projected Discharge Date: _____
Facility Contact Number: _____
UM Name and Number: _____

RECOMMENDED DOCUMENTATION

To assist in determining medical necessity for benefit reimbursement, we **strongly recommend** you provide this clinical documentation, as applicable:

- Current psychiatrist's psychiatric evaluation (within 30 days of the request)
- Detailed psychosocial history
- If currently hospitalized, include the family therapy, individual therapy and doctor's progress notes for the current stay and indication of the outpatient provider support of RTC.
- Clinical information from previous inpatient psychiatric/substance use admissions
- If outpatient, include a letter from each outpatient provider summarizing the intensity of treatment over the past six months and why treatment is failing, or a copy of the treatment records for the past eight visits.

Failure to complete all fields and include the supporting legible documentation could result in an adverse decision.

Diagnostic and Statistical Manual (DSM) Diagnosis:
Is there cognitive/intellectual impairment? ____ Yes ____No If yes, attach copies of psychological tests and describe:

Facility is primarily providing a continuous structured therapeutic program specifically designed to treat behavioral health disorders and is not a group or boarding home, boarding or therapeutic school, halfway house, sober living residence, wilderness camp or any other facility that provides custodial care.

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Are there any significant physical or medical problems? ____ Yes ____No If yes, please describe:

Describe in detail the patient's current condition, including mental status and behavioral symptoms, for which residential treatment might be necessary.

Reasons why the patient cannot be treated at a lower level of care:

What attempts have been made to treat the patient with the maximum intensity of services available at a less-intensive level of care, especially within the past six months?

Treatment/Involvement	Provider(s)	Frequency	Start/End Dates	Comments
Individual therapy				
Family therapy				
Partial hospital				
Psychiatric medication management				
Psychiatric/substance use hospitalizations (last three years)				
Community services				
Child protective services				
Arrests/legal charges				
School services				
Military agencies				
Case management				
Intensive outpatient				

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Current Psychiatric Medications	Dose/Frequency

Past Psychiatric Medication Trials	Start/End Date	Results/Reason for Discontinuation

Substance Type	Amount/Frequency	Duration	Age Started	Last Use	Treatment	Outcome/Results

Describe patient's current family structure and support system (living situation, parental roles, family strengths, areas needing improvement):

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List the goals necessary and attainable for the patient/family within a residential treatment setting. Treatment duration may be several months:
1.
2.
3.

If family involvement is therapeutically contraindicated, please explain:
Do you anticipate any barriers with reunification back into the family home after discharge from RTC?

Family therapy requirements for age 18 and under:

- **The custodial parent/family is required to participate in weekly, on-site family therapy. If due to hardship, however, parents are unable to attend on-site, weekly family therapy must occur, with appropriate documentation, using remote technology-assisted applications.**

  You discussed this requirement with the custodial parent. They understand and agree to participate.

  YES NO