

Please fax completed form to 877-581-1590.

Beneficiary Name: Last		First	M.I.	Beneficiary ID #:	
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	
Completed By:			Proposed Admin Date (mm/dd/yyyy)		
<input type="text"/>			<input type="text"/>		
Date of Birth: (mm/dd/yyyy)		Age:	Phone #:		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Address: Street	Apt.	City	State	Zip Code	
<input type="text"/>					
Home Phone #:	Work Phone #:	Other:			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Other health insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, specify: <input type="text"/>		
Legal Guardian/Parent:	<input type="text"/>				

RTC Application Instructions

This application MUST be completed and signed by the current treating physician, (MD or DO), psychiatrist or clinical psychologist who is recommending treatment in an RTC. Information must be current, based on recent contact with the patient and family. The required documentation listed on page four must be included with the initial RTC application. Incomplete and/or unsigned applications cannot be processed.

Note: Parent/guardian(s) may want to duplicate all of these materials since much of the same information will be required by the facility for which the applicant is being considered.

Services must be provided by a KePRO-Certified TRTC for Children and Adolescents. A current listing is available on the KePRO website: <http://tricare.kepro.com/>

Referring Provider:	<input type="text"/>	License Type:	<input type="text"/>		
Provider Address: Street	Apt.	City	State	Zip Code	
<input type="text"/>					
Provider Tax ID:	<input type="text"/>	Provider NPI #:	<input type="text"/>		
Provider Phone #:	<input type="text"/>	Fax #:	<input type="text"/>		
Provider Point of Contact:	<input type="text"/>	Phone #:	<input type="text"/>		
Patient's current placement:					
<input type="checkbox"/> Home <input type="checkbox"/> Other family <input type="checkbox"/> Hospital <input type="checkbox"/> Foster setting <input type="checkbox"/> Juvenile detention					
DSM 5 Diagnosis:					
<input type="text"/>					

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Relevant medical and psychosocial conditions:

Describe how, as a result of a diagnosed mental disorder, the patient is experiencing:

1. Physical or psychological distress:

2. An impairment in his/her ability to function in appropriate occupational, educational, or social roles:

3. Current mental status and description of symptoms:

Are there any significant physical or medical problems? No Yes If yes, please describe:

Is there a diagnosis of:

- | | | |
|-------------------------------------------------------|----------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> Autistic Disorder | <input type="checkbox"/> Asperger's Disorder | <input type="checkbox"/> Pervasive Developmental Disorder |
| <input type="checkbox"/> Reactive Attachment Disorder | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Fetal Alcohol Syndrome <input type="checkbox"/> None |

Is there cognitive/intellectual impairment? No Yes If yes, attach copies of psychological tests and describe:

Is there a history of paraphilia or sexual deviation disorder? No Yes If yes, describe:

Community or military agencies involved in working with the patient or family:

(Include court/legal history, social services, family advocacy, school system. Child Protective Services)

Living Situation:

Describe currently family structure, parental roles, family strengths, barriers to being managed in the community, areas needing improvement:

Explain why this patient can't be treated at a lower level of care:

Family Involvement:

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If family involvement is therapeutically contraindicated, please explain:

Are any barriers anticipated with reunification back into the family home after discharge from RTC?

Family therapy requirements:

- If the custodial parent resides within 250 miles of the RTC, the custodial parent/family must participate in weekly on-site family therapy.
- If the custodial parent resides more than 250 miles from the RTC, the custodial parent/family must participate in monthly on-site family therapy and weekly geographically distant family therapy (GDFT).
- Failure to participate in family therapy may result in non-authorization.

This requirement has been discussed with the custodial parent, they understand and agree to participate: No Yes

Name of local therapist proposed to participate in GDFT, if applicable:

Is there current or past history of substance abuse? No Yes If yes, describe:

Substance type	Amount/frequency	Treatment	Court involvement	Age Started	Outcome/Results

All current medications	Dosage	Schedule	Start Date	Results

Past psychiatric medication trials	Start/End Date	Results/Reason for discontinuation

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

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Treatment type	Provider(s)	Frequency	Start/End Dates	Response/Outcomes
Individual OP treatment				
Family OP treatment				
Partial hospital/day treatment				
Psychiatric med management				
Psychiatric input stays (last three years)				

List goals you see as necessary and attainable for the patient/family in a residential treatment episode of up to a few months duration:

Proposed TRICARE RTC: Estimated length of stay:

ATTACH REQUIRED DOCUMENTATION TO THIS APPLICATION

(Failure to include all information will result in an inability to process this request.)

1. Current Psychiatric Evaluation by a psychiatrist (within 30 days of this request).
2. Detailed psychosocial assessment.
3. Discharge summaries (from any behavioral health hospitalizations within the last 12 months).
4. Psychological testing results (IQ and projective tests), if applicable.
5. School testing, school social history, and an Individualized Educational Plan (IEP), if applicable.
6. If hospitalized, include the family therapy, individual therapy and MD/DO progress notes for the current stay and a letter indicating the outpatient provider(s) support of RTC.
7. 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.
8. Any other applicable or specialized assessment (e.g., pediatric, neurologic, other).

Physician Certification: This is to certify that I am rendering care to this patient, the above statements are true, and the appropriate signed releases for the information provided to UnitedHealthcare Military & Veterans have been obtained.

Consent has been given by child/adolescent for parents to communicate and act on their behalf applicable for age of majority within the state of residence:

The next page(s) contain the parental attestation form. The provider must obtain parental signature and return to UHC M&V *prior* to admission.

Provider Signature: _____ Credentials: _____ Date: _____

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Please fax the signed Family Therapy Agreement
to UHCMV at 877-579-8589

Family Therapy Agreement
(Must be signed by family)

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the UnitedHealthcare Military & Veterans Information System and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from you in order to manage your TRICARE enrollment, provide your benefits, and/or pay for those services.

ROUTINE USES: Your records may be disclosed to investigate waste, fraud, abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Routine Uses published at <http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx> and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request.

Name of Patient:

Sponsor Social Security Number:

Patient DOB:

DIRECTIONS

The family/legal guardian must complete this RTC attestation. Residential treatment center (RTC) placement cannot be considered without documentation of treatment, including outpatient intensive measures (multiple weekly visits), family therapy and/or acute inpatient admissions. UnitedHealthcare Military & Veterans (UHCMV) will process the request once the physician and family packets have been fully completed and received. Incomplete or illegible documentation will result in a processing delay of this request.

Services must be provided by a KEPRO certified RTC for children/adolescents. A current listing is available on the KEPRO website: <http://tricare.kepro.com>. Choose the Mental Health Facilities tab, go to the right side and click on the Facility Listing Report. Choose the most recent month. This report has a listing of all certified RTCs by state. Please note that prime beneficiaries are required to attend an RTC in their enrolled region.

While a beneficiary is in RTC, there will be an RTC specialist assigned to do clinical reviews during the course of the RTC treatment and if deemed necessary by UHCMV there may also be a UHCMV Behavioral Health Case Management referral in order to assist with concerns and discharge planning. *The Case Manager and RTC specialist work together to help the beneficiary. The intent is to provide a seamless source of support, with attention to times of transition, crisis and stabilization. Cooperation with both these entities would greatly benefit the family and ultimately provide for a smoother transition from RTC to outpatient care once they have been stabilized. Please be prepared to engage with both of these representatives if needed.*

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Family Therapy Agreement
(Must be signed by family)

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FAMILY THERAPY AGREEMENT

The TRICARE RTC benefit is for medically necessary treatment, not for long-term placement. Family participation is required and the goal of treatment is to return the child home. The residential treatment is intended for stabilization, so that treatment can resume on an outpatient basis.

- Family involvement is essential to your child's success while in a RTC. If you live less than 250 miles from the residential treatment facility, you are expected to be on site weekly for a family session with your child's therapist. If you live more than 250 miles away, you are required to either participate in family therapy on site or participate in Geographically Distant Family Therapy (GDFT). If you participate in GDFT, you will attend family therapy sessions **at a therapist's office** near your home three times per month and on site monthly. The GDFT therapist will conduct the session telephonically with you, your child and his/her therapist at the RTC.
- At least one parent/guardian is required to attend one family therapy session per month on site at the RTC.
- GDFT is expected to begin within the first two weeks of the patient's admission to the RTC. Failure to comply with family therapy requirements may result in denial of continued authorization and discharge from the RTC.

I agree to comply with the requirements of family therapy and on-site visits listed above.

Signature Parent/ Guardian: _____ Date: _____

Signature Parent/ Guardian: _____ Date: _____

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