| | **Child and Adolescent 60 Day Clinical Review for Continued Prior Authorization of HCTC**<br>**Form 3.14.11** |
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**(FAX completed form to: Magellan Childrens' Care Management at 1 866-568-6147)**
**Failure to submit update within 4 days will result in denial of Prior Authorization**

| **Reciepent Information** | |
|---|---|
| C/A Name: | Case Manager: |
| Fax: | PNO/QSP: |
| Date this C/A was previously approved for Residential Treatment: | Level of care previously approve: |

The following information is needed to confirm that this Level of Care is still medically necessary because this C/A has not been admitted within 60 days from the date of approval. Please submit this information **via Fax** to the Residential Coordinator within 72 hours for an updated review. You will be notified by **Fax Response form** of this C/A's Level of Care Determination.
**PLEASE INCLUDE** current **psychiatric progress note and any service provider notes.**

| **Current Psychiatric Symptoms/Behaviors** |
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| Date of Last Psychiatric Visit: |
| **Specify an y current Substance Abuse and Treatment that is now being utilized:** |
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| **Current Mental Status:** |
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| **Services/Natural Supports** currently in place to maintain the C/A in the community (Please include frequency, duration, and outcome of services): |
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| **Why does the C/A still require this Level of Care?** (Describe behaviors /symptoms that continue to fail community based services) |
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