Sandhills Center - Service Authorization Request (SAR)

Patient's Name:	
Social Security #:	DOB:
Current Address:	
City/State/Zip:	
Medicaid #: - - None	County (Medicaid Eligibility):
Attending Provider:	
Legal Guardian: None Parent DSS Other: Name:	

DIAGNOSES: Indicate Primary Diagnosis with (P).

DATE OF INITIAL ASSESSMENT and/or Subsequent Assessments prior to referral:
MH SA DD Voluntary Involuntary
Initial Request Reauthorization Discharge ** EXPEDITED** EPSDT

NC SNAP Score___

LOCUS	1 2 3 4 5	**Composite Score**	**LOC Recommendation**
I. Risk of Harm			
II. Functional Status			
III. Co-Morbidity			
IV- a. Recovery Environment. (Support)			
IV-b. Recovery Environment. (Stress)			
V. Treatment and Recovery History			
VI. Engagement			

CALOCUS	1 2 3 4 5	**Composite Score**	**LOC Recommendation**
I. Risk of Harm			
II. Functional Status			
III. Co-Morbidity			
IV- a. Recovery Environment. (Support)			
IV-b. Recovery Environment. (Stress)			
V. Resiliency and Treatment History			
VI-a. Acceptance/Engagement (C&Y)			
VI-b. Acceptance/Engagement (Parent/PS)			

Comments:

ASAM Patient Placement Criteria Adult/Adolescent
(See ASAM criteria for placement considerations)

	I	**II.1/5**	**III.1**	**III.3**	**III.5**	**III.7**	**IV**
I. Withdrawal/Intoxication							
II. Medical Complication							
III. Behavioral/Emotional Cognitive Complication							
IV. Readiness for Change							
V. Relapse/Continued use or problem potential							
VI. Recovery Environment							

Placement Recommendation:

CURRENT(C) and PREVIOUS (P) TREATMENT)

Service	Current / Previous	Comments
Residential	C P	
Mental Health Outpatient	C P	
Mental Health Inpatient	C P	
Substance Abuse Outpatient	C P	
Detox	C P	
Substance Abuse Inpatient	C P	
Other	C P	

SUBSTANCE _____ USE

Drug of Choice N/A	Age of 1st Use	Route of Usage	Frequency	Amount	Date of Last use
Primary:	Years			Per	
Secondary:	Years			Per	
Tertiary:	Years			Per	
Other:	Years			Per	

MEDICAL: Current Primary Care Physician Name: _____ Signed Release to Primary Care Physician? Yes No

Medically- Compliant Non-compliant Comments:

CURRENT MEDICATIONS	Current Regimen	# of months		CURRENT MEDICATIONS	Current Regimen	# of months	
mg		<1	>1	mg		<1	>1
mg		<1	>1	mg		<1	>1
mg		<1	>1	Other:		<1	>1
Allergies:							

Reason for Admission, Continued Stay or other comments:

Request for Service

Service Description & Code	Funding Source	Frequency	Duration	Start Date	End Date	Provider/Site Location	UM ACTION	Units Approved
							Approved Pended Denied-Pt Denied-All	
							Approved Pended Denied-Pt Denied-All	
							Approved Pended Denied-Pt Denied-All	

Clinician Signature: **Requesting Provider:** **Date:**

Sandhills Center Care Management / Utilization Management Use Only

UM COMMENTS:

Utilization Management Clinical Reviewer: Date:

Sandhills Center Care Management / Utilization Management #: 1-800-241-1073 Fax#: 336-389-6543

**Submission does not automatically constitute authorizations. All treatment is subject to medical necessity determination and based on beneficiary eligibility