Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

Initial Residential Authorization Form

COVER PAGE

Upon completion of this form **please fax to 1-866-535-6974** or upload this document to your request via the provider portal at Homestatehealth.com.

Facility Name	
Facility NPI #	
Contact Person Name	
Phone #	
Fax #	
Level of Care / CPT Code Requested	
Modifiers	
Admit Date	
Member Name/DOB	
Attending Physician Name / #	
Other Insurance	
(if yes, please include policy information)	
Guardian name and phone #	
RCST/phone #	
Dx at Admission	
Medical Issues	

CONTINUED NEXT PAGE:

State Custody/Foster Care or DYS	**Yes** ☐ **No** ☐
IA attached	**Yes** ☐ **No** ☐ **N/A** ☐
Recommendation from IA is RTC	**Yes** ☐ **No** ☐
CS9 Attached	**Yes** ☐ **No** ☐
Adoption Subsidy	**Yes** ☐ **No** ☐
If Adoption Subsidy, the Adoption Subsidy worker is aware of Admission	**Yes** ☐ **No** ☐ **N/A** ☐
Court Commit /Ordered: *If yes, attach court order*	**Yes** ☐ **No** ☐
What is the discharge plan at admission:	
Comments (optional):	