



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SPECIAL HEALTH CARE NEEDS

**ADULT HEAD INJURY PROGRAM PRIOR AUTHORIZATION MODIFICATION**

CLIENT NAME (LAST, FIRST, MI)	DCN
PROVIDER NAME	
PROVIDER ADDRESS	CONTACT PERSON

**ADULT HEAD INJURY PROGRAM PRIOR AUTHORIZATION (PA) MODIFICATION FORM**

- A modification form must be completed for each service modified for the participant.
- If a new service or new provider will replace a discontinued service, a new PA must be submitted by the provider in addition to the modification form.

**Cognitive/Behavioral**

- 0005 - Neuropsychological Evaluation/Consultation  
 0006 - Behavioral Assessment and Consultation

**Adjustment Counseling - Individual**

- 0010 - Psychologist  
 0011 - Social Work  
 0012 - LPC

**Adjustment Counseling - Group**

- 0013 - Psychologist  
 0014 - Social Work  
 0015 - LPC

**Community Intergration**

- 0004 - Transitional Home and Community Support  
 0138 - Socializations Skills Training (3 hr half day)

**Educational/Vocational**

- 108 - Pre-Voc/Pre-Emp Training (3 hr half day)  
 0008 - Pre-Voc/Pre-Emp Training (6 hr half day)  
 0009 - Supported Employment-Long Term Follow-Up  
 0007 - Special Instruction

**Transportation**

- 0026 - Individual  
 0027 - Group Same Location  
 0028 - Group

COMMENTS: PROVIDER MUST JUSTIFY REASON FOR THE INCREASE OR DECREASE IN THE COMMENTS SECTION.

MONTH / YEAR	ORIGINAL AUTHORIZED UNITS	REQUESTED MODIFIED UNITS

SERVICE COORDINATOR ONLY		PROGRAM MANAGER ONLY	
DATE RECEIVED		<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED	DATES OF APPROVAL TO
RECOMMENDATION		COMMENTS	
<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> MODIFY			
SERVICE COORDINATOR'S SIGNATURE		PROGRAM MANAGER'S SIGNATURE	
UPON COMPLETION - INITIAL AND DATE	MOHSAIC ENTRY	SENT TO PROVIDER	SENT TO S.C.