



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 SPECIAL HEALTH SERVICES
 ADULT BRAIN INJURY (ABI) PROGRAM PRIOR AUTHORIZATION

SECTION #1 COMPLETED BY PROVIDER

ORIGINAL AUTHORIZATION <input type="checkbox"/>		MODIFICATION <input type="checkbox"/>		DATE:	
PARTICIPANT NAME (LAST, FIRST, MI)		DATE OF BIRTH	AGE	DCN NUMBER	
PARTICIPANT ADDRESS (STREET, CITY, STATE, ZIP)				COUNTY	
PROVIDER NAME				TELEPHONE NUMBER	
PROVIDER ADDRESS			SUBMITTED BY:		
SERVICE REQUESTED:					
<input type="checkbox"/> 0010 – Adjustment Counseling/Psychologist <input type="checkbox"/> 0011 – Adjustment Counseling/Social Work <input type="checkbox"/> 0012 – Adjustment Counseling/LPC		<input type="checkbox"/> 0005 – Neuropsychological Eval/Consultation <input type="checkbox"/> 108 – Pre-Voc/Pre-Emp Training (3 hr half day) <input type="checkbox"/> 0008 – Pre-Voc/Pre-Emp Training (6 hr)		<input type="checkbox"/> 0009 – Supported Emp-Long Term Follow-Up <input type="checkbox"/> 0007 – Special Instruction <input type="checkbox"/> 0004 – Transitional Home and Community Support	
List month/year and total number of original units requested or modified units requested. If this is a modification request, please justify reason for the increase or decrease in this section:					
Month/Year	Units requested	Month/Year	Units requested	Month/Year	Units requested
Month/Year	Units requested	Month/Year	Units requested	Month/Year	Units requested

SECTION #2 COMPLETED BY ABI PROGRAM

DATE RECEIVED BY SERVICE COORDINATOR: _____		S.C. COMMENTS:	
Participant on Waiting List? <input type="checkbox"/> Yes <input type="checkbox"/> No			
S.C. RECOMMENDATION: <input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Approved with modification		S.C. SIGNATURE:	
Final Program Review <input type="checkbox"/> Approved (See below) <input type="checkbox"/> Denied Comments:			
MONTH/YEAR	APPROVED UNITS	UNIT COST	TOTAL COST FOR MONTH
PROGRAM MANAGER'S SIGNATURE:	TOTAL APPROVED UNITS:		GRAND TOTAL COST:
MOHSAIC ENTRY COMPLETED (DATE AND INITIALS)	DATE MAILED TO PROVIDER	DATE MAILED TO SERVICE COORDINATOR	

INSTRUCTIONS FOR COMPLETION OF THE ABI PROGRAM PRIOR AUTHORIZATION FORM

Section #1 Completed by the Provider of Services

This row:	Should contain:
First set of boxes	Mark appropriate box indicating original authorization or modification; and enter date submitted
Participant Name	Enter participants name (Last, First, MI)
Date of Birth	Enter participants date of birth
Age	Enter participants age
DCN Number	Enter participants DCN number
Address	Enter participants address (Street, City, State, Zip)
County	Enter participants county of residence
Provider Name	Enter providers business name
Telephone Number	Enter telephone number for person submitting form
Provider Address	Enter providers address
Submitted By	Enter name of person submitting the form
Service Requested	Check the box of the service requested (check only 1)
List month/year and total number of units requested	Enter the month/year, and total number of units requested. If this is a modification request, please justify reason for the increase or decrease in this section.

Section #2 Completed by ABI Program

Date received by Service Coordinator	Enter the date SC received the form from Provider
Participant on waiting list?	Check either the Yes or No box indicating if participant is on waiting list
S.C. Recommendation	Check either Approved, Denied, or Approved with modification
Service Coordinator Comments	Enter any comments about services or any modification comments
Service Coordinators Signature	Enter signature
Final Program Review	Check either Approved or Denied
Comments	Enter any comments about services or any modification comments
Month/Year	Enter month/year of service approved
Approved Units	Enter number of units approved for the month
Unit Cost	Enter cost of service unit
Total Cost For Month	Enter total dollar amount of cost of service approved for the month (Approved units multiplied by unit cost)
Program Manager's Signature	Enter signature
Total Approved Units	Enter total number of units for all months approved
Grand Total Cost	Enter grand total cost of all months approved
MOHSAIC entry completed	Enter initials of person that entered service plan into MOHSAIC and the date entered
Date mailed to provider	Enter date form was mailed to Provider from DHSS
Date mailed to S.C.	Enter date form was mailed to Service Coordinator from DHSS