



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
SPECIAL HEALTH SERVICES

**ADULT BRAIN INJURY PROGRAM PRIOR AUTHORIZATION MODIFICATION**

**COMPLETED BY PROVIDER**

CLIENT NAME (LAST, FIRST, MI)		DATE OF BIRTH	DCN
PROVIDER NAME			DATE
PROVIDER ADDRESS			CONTACT PERSON
<b>SERVICE REQUESTED:</b> <input type="checkbox"/> 0005 - Neuropsychological Evaluation/ Consultation <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"/> 108 - Pre-Voc/Pre-Emp Training (3 hr half day) <input type="checkbox"/> 0008 - Pre-Voc/Pre-Emp Training (6 hr full day)	<input type="checkbox"/> 0004 - Transitional Home and Community Support <input type="checkbox"/> 0007 - Special Instruction <input type="checkbox"/> 0009 - Supported Employment-Long Term Follow-Up

**COMMENTS:** PROVIDER MUST JUSTIFY REASON FOR THE INCREASE OR DECREASE IN UNITS REQUESTED.

MONTH / YEAR	ORIGINAL AUTHORIZED UNITS	REQUESTED MODIFIED UNITS

**ABI SERVICE COORDINATOR ONLY** **ABI PROGRAM MANAGER ONLY**

DATE RECEIVED: _____ CURRENT MOHSAIC SCA DATE: _____ <b>RECOMMENDATION:</b> <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> MODIFY	<input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED	DATES OF APPROVAL TO
	PROGRAM MANAGER'S COMMENTS:	
SERVICE COORDINATOR'S COMMENTS:	PROGRAM MANAGER'S SIGNATURE:	
	MOHSAIC ENTRY COMPLETED (DATE AND INITIALS):	
SERVICE COORDINATOR'S SIGNATURE:	DATE MAILED TO PROVIDER:	DATE MAILED TO SERVICE COORDINATOR: