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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH CARE NEEDS

ADULT BRAIN INJURY (ABI) PROGRAM PRIOR AUTHORIZATION

DATE

SECTION #1 COMPLETED BY THE PROVIDER OF SERVICES

PARTICIPANT NAME (LAST, FIRST, MI)	DATE OF BIRTH	DCN

PARTICIPANT ADDRESS (STREET, CITY, STATE, ZIP)	COUNTY

PROVIDER NAME	TELEPHONE NUMBER

PROVIDER ADDRESS	SUBMITTED BY

SERVICES REQUESTED

- ☐ 0005 - Neuropsychological Evaluation/Consultation
- ☐ 0010 - Adjustment Counseling/Psychologist
- ☐ 0011 - Adjustment Counseling/Social Work
- ☐ 0012 - Adjustment Counseling/LPC
- ☐ 108 - Pre-Voc/Pre-Emp Training (3 hr half day)
- ☐ 0008 - Pre-Voc/Pre-Emp Training (6 hr full day)
- ☐ 0107 - Consultation Visit
- ☐ 0004 - Transitional Home and Community Support
- ☐ 0007 - Special Instruction
- ☐ 0009 - Supported Employment-Long Term Follow-Up

List month/year and total number of original units requested.

MONTH/YEAR	UNITS REQUESTED

SECTION #2 COMPLETED BY ABI PROGRAM STAFF

DATE RECEIVED BY SERVICE COORDINATOR (S.C.)	S.C. COMMENTS
PARTICIPANT ON WAITING LIST? ☐ Yes ☐ No	
CURRENT MOHSAIC SCA DATE	

S.C. RECOMMENDATION	S.C. SIGNATURE
☐ Approved ☐ Denied ☐ Approved with modification	

FINAL PROGRAM REVIEW
☐ Approved ☐ Denied

PROGRAM MANAGER'S COMMENTS

MONTH/YEAR	APPROVED UNITS	UNIT COST	TOTAL COST FOR MONTH
		$	$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
			$
PROGRAM MANAGER'S SIGNATURE	TOTAL APPROVED UNITS 0		GRAND TOTAL COST $ 0.00
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:
Date	Enter date submitted
Participant Name	Enter participants name (Last, First, MI)
Date of Birth	Enter participants date of birth
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

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
Current MOHSAIC SCA Date	Enter the most recent SCA date from the MOHSAIC
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
Program Manager's 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 form 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 date service plan was entered into MOHSAIC and initials of person that entered service plan
Date mailed to provider	Enter date form was mailed to Provider from DHSS
Date mailed to Service Coordinator	Enter date form was mailed to Service Coordinator from DHSS