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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF SPECIAL HEALTH CARE NEEDS

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

SERVICE 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 half day)
- ☐ 0004 - Transitional Home and Community Support
- ☐ 0007 - Special Instruction
- ☐ 0009 - Supported Employment-Long Term Follow-Up

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

MONTH/YEAR	AUTHORIZED UNITS	REQUESTED MODIFIED UNITS

ABI SERVICE COORDINATOR ONLY

DATE RECEIVED

CURRENT MOHSAIC SCA DATE

RECOMMENDATION

☐ APPROVED ☐ DENIED ☐ MODIFY

SERVICE COORDINATOR'S COMMENTS

SERVICE COORDINATOR SIGNATURE

ABI PROGRAM MANAGER ONLY

☐ APPROVED ☐ DENIED

DATES OF APPROVAL

TO

PROGRAM MANAGER'S COMMENTS

PROGRAM MANAGER'S SIGNATURE

MOHSAIC ENTRY COMPLETED (DATE AND INITIALS)

DATE MAILED TO PROVIDER

DATE MAILED TO SERVICE COORDINATOR