Finance Use Only:
Auth #:_____
Activity Code:_____

St. Clair County Community Mental Health

Specialized/Enhanced Medical Equipment and Supplies, Environmental Modifications and/or Enhanced Pharmacy

Part I: Request Details

Requester/Case Holder:

Date of Request: _____

Requesting Staff: _____ Case Holder: _____

Individual: _____ Case #: _____

Contact Person and/or Guardian: _____ Phone #: _____

Address: _____

Corporation Name/Home Name (if applicable): _____

Months Request Would Cover (if applicable): _____
(ex: Jan, Feb, March) Prescription Drugs - 6 months max; Supplies – 3 months max

Current Identified Need:

_____
_____

Preliminary Estimate of Most Cost-Effective Solution: _____

What Other Coverage Options Have Been Attempted/Taken:

_____
_____

Part II: Financial Information & Recommendation

Case Holder/OT Staff:

Individual on H/SW?: ☐ Yes ☐ No

Medicaid Verification: _____ _____ _____
***Medicaid is a Requirement** Medicaid Number Initials Date

For Prescription Requests Only:

NOTE: Individual/Guardian will be responsible for any co-pays.

Additional Insurance(s): ☐ Medicare ☐ Private Insurance (i.e. Aetna, BCBS, etc.): _____ _____
Initials Date

Financial Information Letter Sent to Contact Person/Guardian: _____ _____
Initials Date

Finance Department:

Medicaid Verified & Proof Attached: _____ _____
Initials Date

All Required Financial Information Received & Attached: _____ _____
Initials Date

Recommendation:

☐ Suggested for Approval, Proceed to Chief Clinical Officer for Review (found on page 3)

☐ Suggested for Denial, explanation: _____

Clinical Form: #03-0091
Revised Date: 7/1/2024
Admin Procedure Ref: #07-003-0065
EHR: Administrative/Financial, Other Administrative/Financial Documents, Funding, Supp & Service Request

Part IV – Requested Prescription, Equipment, and/or Supplies Details

****Please verify that the Chief Clinical Officer has completed Part III before continuing to this section****

Requester/Case Holder

Please make sure to attach the following required document (when applicable):

- Physician's Prescription (good for 1 year from signature date) or Certificate of Medical Necessity signed by Physician.
  - **NOTE:** Repairs to equipment do not require this documentation.
- Landlord/Property Owner Agreement when environmental modifications are recommended (if applicable).
- Screenshot/Copy of Quotes and/or Price Estimates.
- Three estimates when the expected cost of the modification will exceed $10,000.

Description of Services: (please include brand name(s)/module numbers if applicable)	**Request Type** (Routine, Emergency, One Time, etc.)	**Quantity**	**Charge**

0.0 **Total Quantity** $0.00 **Total Charge**

Prospective Service Provider Name: _____ Phone #: _____

Prospective Service Provider Address: _____

Reimbursement Other Than Home (if applicable): _____

Clinical Form: #03-0091
Revised Date: 7/1/2024
Admin Procedure Ref: #07-003-0065
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Part III – Preliminary Approval/Denial

Chief Clinical Officer:

☐ Preliminary Approval to Proceed

☐ Request Denied

Reason for Denial: _____

_____ _____ _____

Chief Clinical Officer/Designee Signature | Print Name | Date

****If request is denied, then no further action is required on this form****

**** If request is approved, continue to Part IV on page 2****

Part V – Final Approval/Denial

Chief Clinical Officer:

☐ Payment Approved

☐ Payment Denied

Reason for Denial:

_____

_____

_____ _____ _____

Chief Clinical Officer/Designee Signature | Print Name | Date

Document Checklist:

☐ Fill out Form
☐ Complete Current Financials
- Bank Statement(s)
- Resident Funds Part II (if applicable)

☐ Quotes/Price Estimates
☐ Documentation of Medical Necessity
- Healthcare Provider (prescription)
- Other Healthcare Professional (supplemental justification)

☐ Proof of Medicaid Coverage
☐ Letter of Denial from Pharmacy/Insurance

Workflow Process:

☐ Part I – Requester/Case Holder
☐ Part II – Case Holder/OT Staff
☐ Part III – Finance Department
☐ Part IV – Requester/Case Holder
☐ Part V – Chief Clinical Officer
☐ Return to Finance
☐ Forward Final Copy to Case Holder
☐ Scan/Upload into OASIS