Authorization Form for Statewide Inpatient Psychiatric Program (SIPP) / Residential Treatment Center

Enrollees enrolled in Child-Welfare Specialty Plan-

This is to certify that:

Enrollee's Name_____ Date_____

Medicaid Identification_____ DOB_____

has been screened and recommended by a multidisciplinary team (MDT) for admission to a statewide inpatient psychiatric program (SIPP), the requesting provider has reviewed and agrees with the MDT and Suitability Assessment, and that the above enrollee meets medical necessity criteria for SIPP, as defined in the Florida Community Based Services medical necessity criteria found on www.sunshinehealth.com.

These services are to be provided by: _____ (provider agency),

as authorized by:_____ (provider signature)

Admission date: _____

The enrollee is eligible for Statewide Inpatient Psychiatric Program (SIPP) as follows:

☐ The enrollee meets SIPP eligibility criteria for this level of care.

☐ Multidisciplinary Team has determined the enrollee is in need of this service *(Please include a copy of the suitability assessment and MDT with this authorization form)*.

***Services will be reviewed and reauthorized every 21 days for enrollees under age 10 and every 30 days for enrollees over age 10.*

Enrollees enrolled in Managed Medical Assistance (MMA) Plan-

This is to certify that:

Enrollee's Name_____ Date_____

Medicaid Identification_____ DOB_____

has been screened for admission to a statewide inpatient psychiatric program (SIPP), and the requesting provider completed all admission criteria as defined in the Florida Community Based Services medical necessity criteria found on www.sunshinehealth.com.

These services are to be provided by: _____ (provider agency),

as authorized by:_____ (provider signature)

Admission date: _____

The enrollee is eligible for Statewide Inpatient Psychiatric Program (SIPP) as follows:

☐ The enrollee meets eligibility criteria for this level of care.

- Requesting provider or Multidisciplinary Team has determined the child is in need of this service (Please include a copy of all initial assessments applicable to admission criteria with this authorization form). A DSM V or ICD-10 Diagnosis
- A description of the initial treatment plan relating to the admitting symptoms
- Current symptoms requiring SIPP treatment
- Medication history
- Prior hospitalizations
- Documentation that the child or adolescent is mentally competent, has age appropriate cognitive ability and is sufficiently stable cognitively to benefit from treatment
- Documentation that the child or adolescent is in good physical health, as certified by a medical doctor (MD), doctor of osteopathy (DO), registered nurse, physician's assistant, or other professional who has the authority to perform physical examinations of a medical nature
- Prior alternative treatment
- Appropriate medical, social and family histories
- Proposed aftercare placement/community-based treatment

☐ Requesting provider or Multidisciplinary Team has determined the child is in need of this service (Please include a copy of all initial assessments applicable to admission criteria with this authorization form).

***Services will be reviewed and reauthorized every 21 days for enrollees under age 10 and every 30 days for enrollees over age 10.*

CBC: _____
Coordinator Name: _____
Region: _____
Fax Number: _____
Phone Number: _____
Email: _____

Please feel free to attach additional documentation to support your request.

SUBMIT TO:
Utilization Management Department
1301 International Parkway, Suite 400
Sunrise, FL 33323
PHONE: 866.796.0530 | Child-welfare 855.463.4100
FAX 844.244.9755