**RETROSPECTIVE REVIEW REQUEST FORM**

**BERRIEN MENTAL HEALTH AUTHORITY**

**d/b/a RIVERWOOD CENTER**

**This form is for hospitals and crisis residential providers** that seek a retrospective review of services provided without pre-authorization from Riverwood Center. A pre-screen is needed to determine medical necessity and to provide initial authorization for psychiatric hospitalization, partial hospitalization, and crisis residential. For a narrow category of services provided in urgent or emergent situations a retrospective review process shall apply when:

* Obtaining pre-authorization for and/or discharging from an identified setting would have jeopardized the health or safety of the individual, or
* Inaccurate County of Financial Responsibility (COFR) or insurance information is provided to the provider, or
* The individual presents in such a disorganized state that insurance or residence information is not attainable, or
* The individual was not Medicaid or Healthy Michigan Plan eligible at the time of service and became retroactively enrolled.

Please indicate and explain the reason for the retrospective review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you reach out to BMHA to have a prescreen conducted? Yes / No

If no, why did you not obtain a prescreen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you send documentation to Southwest Michigan Behavioral Health for concurrent review? Yes / No

If no, why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Hospital/Facility Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Your Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address to Send Decision To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consumer Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Admission: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Authorized Units Requesting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure codes and any applicable modifiers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This information submitted is true and accurate to the best of my ability and belief.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

With this form you should include supporting medical necessity documentation for the dates of service of your authorization request:

* History and physical notes from both ER and psychiatric unit
* Nurse’s notes from both ER and psychiatric unit
* Doctor’s notes from both ER and psychiatric unit
* Social Worker notes
* Emergency room notes
* Lab work
* Assessments (risk, suicide, violence etc.)
* Any other pertinent psychiatric information

Please direct any questions to the Utilization Review Specialists at (269) 934-3475 or (269) 934-3476

**Please send the completed form all with all supporting documentation in one of the following ways:**

|  |  |  |
| --- | --- | --- |
| **Mail:**Berrien Mental Health AuthorityAttn: Claims Specialist / Retro ReviewPO Box 547Benton Harbor, MI 49023 | **Fax:**269-934-3388Attn: Claims SpecialistRe: Retro Review | **Secure Email:**externalclaims@riverwoodcenter.orgSubject: Retro Review |

FORM 07-20-02 updated 2/2024