Authorization for Restorative Services

☐ Initial Authorization *(requires physician signature)*

☐ Semi-Annual Authorization *(required every 6 months for congregate residences)*

☐ Annual Authorization *(required every 12 months for apartment programs)*

**Authorization required upon transfer to a different category of adult program. The authorization renewal must, in the case of a transfer from congregate to apartment, occur upon the expiration date of the current authorization. In the case of a transfer from apartment to congregate, the authorization must occur within six months of admission to the new program or the expiration of the current authorization, whichever comes first.*

**Reauthorizations can only be signed by a physician or physician assistant or nurse practitioner specializing in psychiatry in NY State.*

Client Name: _____ Date of Birth_____ Medicaid Number:_____

I, the undersigned licensed physician, based on my review of the assessments made available to me (*and a face-to-face contact with the client for the initial authorization*), have determined that

_____ would benefit from the provision of mental health restorative
(Client Name)
services as known to me and defined pursuant to Part 593.4 (b) of 14 NYCRR and successor documents.

M.D. Signature **Printed Name of M.D.** **Date of Signature**

☐ **Check to verify you are a Medicaid Provider** **M.D. NYS Licensure Number**

Physician Assistant (PA)/Nurse Practitioner in Psychiatry Signature(NPP) **Printed Name of PA/NPP** **Date of Signature**

☐ **Check to verify you are a Medicaid Provider** **PA/NPP NYS Licensure Number**

(PA/NPP Signatures on reauthorizations only)

TO BE COMPLETED BY EAST HOUSE STAFF:

ICD.10 Diagnosis: _____This determination is in effect for the period

of _____ to _____
☐ ***Admission Date*** ☐ ***Renewal date***

☐ Client is enrolled in Managed Care (e.g., an HMO or Managed Care Coordinator Program) and primary care physician name and managed care provider identification number is entered.

☐ For semi-annual and annual authorization: Most recent Service Plan Review attached for physician, physician assistant or nurse practitioner specializing in psychiatry review.