St. Clair County Community Mental Health Authority
3111 Electric Ave. Port Huron, MI. 48060

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

PART I

REQUESTER/CASE HOLDER

Individual: _____ Case #:_____ Date: _____

Requesting Staff: _____ Case Holder: _____

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

Address: _____

If Applicable Corporation Name/Home: _____

If Prescription- List Months Needed:_____
Prescriptions - 6 month max, Supplies - 3 month max (ex. Jan, Feb, March)

Current need and preliminary estimate of most cost effective solution: _____

_____

_____

_____

What options if any have been attempted/taken: _____

_____

_____

CASE HOLDER/OT MUST COMPLETE

- Individual on H/SW ☐Yes ☐ No
- Individual's Medicaid has been verified _____ _____
  Medicaid is a requirement Initials Date
- Medicaid Number: _____

  Completed for prescription ONLY, INDIVIDUAL RESPONSIBLE FOR CO-PAYS
- Additional Insurances ☐ Medicare ☐ Private Insurance (i.e. Aenta, BCBS etc.):_____
- Financial informational letter forwarded to contact person and/or guardian _____ _____
  Initials Date

ACTIVITY CODE (Finance use only): _____

PART II

FINANCE DEPARTMENT

- Individual's Medicaid has been verified _____ _____ (proof attached)
  Initials Date
  Individuals' Medicaid #_____ *Medicaid is a requirement
- Additional Insurances ☐ Medicare ☐ Private Insurance (i.e. Aetna, BCBS etc.):_____
- All needed Financial information has been received _____ _____
  Initials Date

Finance Department Recommendations:

☐ Suggested Approval to Proceed to Program Director

☐ Suggested Denial: _____

_____

_____

PART III

PROGRAM DIRECTOR

☐ Preliminary Approval to Proceed: _____ _____ _____
Signature/Credentials Print Name Date

☐ Request Denied ***If denied, no further action required**

Reason: _____

_____

_____

_____

_____

_____ _____ _____
Signature/Credentials Print Name Date

PART IV

REQUESTER/CASE HOLDER - ONLY COMPLETE IF "Preliminary Approved to Proceed"

Description of services (SCCCMHA is payer as last resort: note the date and also if it is routine, emergency, non-routine, non-emergency, or if it is equipment; for equipment also include brand name/model number if applicable)	**Quantity**	**Charge**

Total Quantity: _____ **Total Charge:** _____

Prospective Service Provider Name: _____ Phone: _____

Prospective Service Provider Address: _____

Reimbursement other than to Home: _____

The following documentation of medical necessity must be included:

☐ **Health Care Provider** Prescription ☐ Yes ☐ No

☐ **Other Healthcare Profession:** Supplemental Justification

☐ Yes ☐ No

PART V

PROGRAM DIRECTOR

FINAL APPROVAL/DENIAL OF PROGRAM DIRECTOR

☐ PAYMENT APPROVED
☐ PAYMENT DENIED; explain: _____

_____

Program Director: _____ _____ _____
Signature/Credentials Print Name Date

Work Flow Process:

☐ Part I- Requester/Case Holder
☐ Part II- Finance Department
☐ Part III- Program Director
☐ Part IV- Requester/Case Holder
☐ Part V- Program Direct
☐ Return to Finance
☐ Return to Case Holder
☐ Scan/Uploaded OASIS