HAVEN HOUSE
Restoring Hope. Renewing Lives.™

Statement of Medical Necessity for Psychiatric Rehabilitation Services (PRS) and Mobile Psychiatric Rehabilitation Services (MPRS)

Date:_____

Patient:_____

DOB: _____ SSN: _____

Diagnosis:_____

_____

_____

_____

_____

Recommended frequency for Psychiatric Rehabilitation Services / Mobile Psychiatric Rehabilitation Services (*suggested amount*)

Number of days per week (please circle) - 1 2 3 4 5

Recommended duration of this service (Lehigh /Northampton County Funding only)

Total Units Requested: _____ (1 unit = 15 minutes) County Contract Only

Due to severity of symptoms and impairment, participation in Psychiatric Rehabilitation Services is recommended in order to maintain stability while improving member's quality of life.

Physician Signature _____ **Date:** _____

Printed Name: _____ **Date:** _____

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Haven House Referral Form PRS /MPRS

Date: _____

First Name:	Last Name:	Date of Birth:
SS#	Phone #	Email Address:
Referral Source	Referral Source Type	Referral Phone #
Primary Insurance: Magellan or Lehigh/Northampton County Funding.		
Secondary Insurance:		
Street Address	Floor, Apt#, etc.	City & State / Zip Code
Past Mental Health Provider:		
Haven House Staff Use Only		
PRS **MPRS**	*Medical Necessity is required.*	
Date and Time Scheduled for Tour		

***Information*:**

_____

_____

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