

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

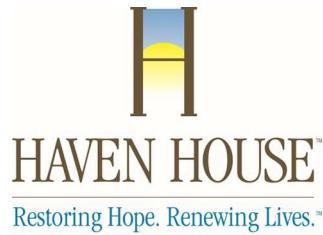
Recommended duration of this service (Lehigh / Northampton County Funding only)

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:** _____



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:			
<i>Haven House Staff Use Only</i>			
PRS	<i>Medical Necessity is required.</i>		
MPRS			
Date and Time Scheduled for Tour			

Information:
