

TCOOMMI
Request for 46B Reimbursement Pre-Authorization Form

LMHA Facilitating Reimbursement: Tropical Texas Behavioral Health

Jail Requesting Reimbursement: _____

Defendants Name: _____
 Defendants SSN#: _____ Defendants DOB: _____
 Defendants SID: _____ Current Jail Location: _____
 Hospital of Release: _____ Date of Hospital Discharge: _____
 Hospital Diagnosis: _____ CARE ID #: _____

- Required Attachments:
- Order of Competency Restoration
 - State Hospital Continuity of Care Plan
 - Order of Release to Stand Trial with Determination of Competency
 - Jail's plan of care (must match State Hospital Continuity of Care Plan)

Projected Costs for Pre-Authorization by TCOOMMI

	Medication(s)	Dosage	Cost Per Day	Planned # of Days	Projected Cost
M1			\$		\$
M2			\$		\$
M3			\$		\$
M4			\$		\$
M5			\$		\$
M6			\$		\$
Sub-Total Projected Medication Cost					\$

	Lab Tests	Cost Per Test / Draw	Planned # of Tests / Draws	Projected Cost
L1		\$		\$
L2		\$		\$
L3		\$		\$
L4		\$		\$
L5		\$		\$
L6		\$		\$
Sub-Total Projected Lab Costs				\$

	Psychiatric Service Encounters (specific encounter type)	Cost Per Service Encounter	Anticipated # of Encounters (bby type)	Projected Cost
P1		\$		\$
P2		\$		\$
P3		\$		\$
Sub-Total Projected Psychiatric Services				\$

Total Pre-Authorization Request **\$**

LMHA Review by: _____
 TTBH TCOOMMI Prog. Director

Date: _____

TCOOMMI Review by: _____
 TCOOMMI Fiscal Manager

Date: _____

Pre-Authorization Approved by: _____
 TCOOMMI Director

Date: _____