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 Service / Mobile Psychiatric Rehabilitation Services (*this is just a suggestion*)

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

If specific days are recommended, please check applicable boxes:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Recommended duration of this service (this is for 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:** _____