

When complete, please fax to **1-855-396-5750**.

**Please type or print clearly. Incomplete and illegible forms will delay processing.**

Prior authorization is required for outpatient services. For psychological and neurological testing, please submit the Testing Outpatient Request Form.

**Electroconvulsive therapy (ECT) services must have prior authorization by telephonic review. Please call 1-866-688-1137.**

**Out-of-network providers:** Prior authorization and a non-contracted provider form are required for all services.

<b>Member information</b>	
Member name:	Member ID number:
Social Security number:	Date of birth:
Member address:	City, state, ZIP code: Phone:
Who referred member for treatment? <input type="checkbox"/> Self <input type="checkbox"/> Primary care provider (PCP) <input type="checkbox"/> State agency <input type="checkbox"/> Other: _____	
Name of referring agency:	Phone:
<b>Treating provider information</b>	
Name (with credentials):	<input type="checkbox"/> NPI : _____ <input type="checkbox"/> In network <input type="checkbox"/> Out of network <input type="checkbox"/> In credentialing process
Phone:	Fax:
Address:	City, state, ZIP code:
Group name/number:	
Contact name:	Treating provider signature:
<b>Reason for services</b>	
Primary reason or complaint:	Start date requested:
Service codes requested:	Frequency:
<b>DSM diagnosis</b>	
List all Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses (behavioral health and medical).	
<b>Supports and care coordination</b>	
1. Is the member currently participating in any vocational services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Is the member's family or supports involved in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has the member been evaluated by a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Is there coordination with other substance use providers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Is there coordination of care with other behavioral health providers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is there coordination of care with medical providers? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Medications</b>	
Is member on prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is member compliant with medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
Prescribing providers:	Medications and dosages:

**Please attach the current treatment plan.** Include documentation related to progress on goals and any changes made as a result.

<b>Additional comments</b>