

When complete, please fax to **1-844-211-0972**.

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 1-888-978-0151.

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

Member information	
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:
Treating provider information	
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:	Group name/number:
Treating provider signature:	
Reason for services	
Primary reason or complaint:	Start date requested:
Service codes requested:	Frequency:
DSM diagnosis	
List all Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses (behavioral health and medical).	
Supports and care coordination	
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	
Medications	
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.	
Additional comments	