PRIOR AUTHORIZATION REQUEST FOR BEHAVIORAL HEALTH OUTPATIENT SERVICES

Each field must be completed

Incomplete documentation will be returned to requesting provider

Fax completed form to: 833-523-2627

□ **TCM** □ **ICM** □ **PSR** □ **Other**_____			
MEMBER INFORMATION:			
Member Name & DOB:		Identification Number:	Referring Date:
Member Address:		Member Phone Number:	
ORDERING PHYSICIAN INFORMATION: □ **In Network** □ **Out of Network**			
Referring Physician:		Phone Number:	Fax Number:
Referring Physician's Address:		**Referring Physician's Signature/License Number:**	
TIN/NPI:	**Location Code:**		
SERVICING PROVIDER / FACILITY INFORMATION: □ **In Network** □ **Out of Network**			
Refer to (Provider Name):		Refer to (Facility Name):	
Refer to (Provider Address):		Refer to (Facility Address):	
Contact Person:	Specialty:		
Phone Number:	Fax Number:	Phone Number:	Fax Number:
TIN/NPI:	**Location Code:**	**TIN/NPI:**	**Location Code:**

REQUESTED SERVICE/PROCEDURE/COURSE OF TREATMENT

POS: □ CMHC □ Hospital Outpatient □ Office □ Home □ Other

If Other, please specify:

Type of Service Request: ☐ Initial Request ☐ Continued Services Request

Each column below must be completed or will be returned to sender as an incomplete Prior Auth Request

Diagnoses (Must include ICD 10 Code(s):	**HCPCS/CPT Code(s):**	**Code Description:**	**Dates of Service**		**# Units**
			Start date	**End Date**	

Providers must submit clinical information to support medical necessity of requested services.

Specific clinical information requirements for Behavioral Health Adult Targeted Case Management (TCM), Adult Intensive Case Management Team Services (ICM), and Psychosocial Rehabilitation (PSR) prior authorization requests is located on MMM's website: https://www.mmm-fl.com/

MUST INDICATE TYPE OF REQUEST BELOW:	
☐ Standard/Routine	
☐ **Expedited/ Urgent**	**Must be signed by treating physician**. By signing below, I certify that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. _____ Physician's signature _____/_____/_____ Date Signed

Please complete all sections of this form. Incomplete forms and/or missing clinical information will be returned to requesting provider as an incomplete prior authorization request.

Fax completed form and clinical information to 833-523-2627.