



**Mental Health Services Authorization Form**  
**1(877) 225-2243 Toll-Free Phone**  
**(503) 345-5704 Phone**  
**(503) 345-5754 Fax**

Today's Date: \_\_\_\_\_

**Member Name:** \_\_\_\_\_ **Recipient ID#:** \_\_\_\_\_

Provider Group Name: \_\_\_\_\_ Fax#: ( ) \_\_\_\_\_

Requesting Practitioner Name: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

Presenting Problem/Symptoms:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5 Axis Diagnosis**

Please indicate type of service, number of units, frequency of current visits and estimated frequency of requested visits.

<u>CPT Codes</u>	<u>Number of Units</u>	<u>Current Frequency</u>	<u>Requested Frequency</u>
Ex: <u>90805</u>	<u>10</u>	<u>weekly</u>	<u>monthly</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If Re-Authorization or if Current Patient (Please Include):  
 Date Member First Started Treatment: \_\_\_\_\_

Please Indicate Member's Progress since Last Auth  
 improved     stable     worsened

Clinical Focus/Expected Outcome (Rationale for Requested Services):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Signature of Requesting Clinician** \_\_\_\_\_

**Attention Requesting Provider:**

- Payment of benefits is contingent upon eligibility, prior authorization requirements, final diagnosis from physician and exclusion and limitations of contract.
- Providers agree to accept OHP/CMS rates for services provided under this authorization, unless otherwise indicated in a contract with FamilyCare, Inc.
- Additional documentation may be requested (current assessment, treatment plan and chart notes).

Confidentiality Note:



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