PerformCARE®

Certified Recovery Specialist Authorization Request/Discharge Form

Out of Network (OON) Providers: A detailed rationale for utilizing an OON Provider including why an INN Provider is unable to meet the member's treatment needs must be included with your request.

Must be submitted and approved by PerformCare prior to service initiation. The information on this form is afforded heightened privacy protection pursuant to the requirements of 42 C. F. R. Part 2 and other state law and regulation. (Ages 18+)

Member Information

Member Name: _____ MAID: _____ DOB: _____

Member Address: _____ Phone #: _____

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Provider Information

Provider Name: _____

Provider Address: _____ Phone #: _____

Person Completing Form: _____

Check One: ☐ Initial ☐ Continued Stay** ☐ Discharge (Date: _____)

** Individual Recovery Plan must be attached for all continued stay requests

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CPT code: H0038 (1 year, 3600 units max)

*** When submitting for claims, add the GT modifier for telephone services and add the HQ modifier when submitting for group services.*

Date Referral Complete and Member Approved for services (Authorization Start Date): _____

Represents date the provider has complete referral information and Member is in agreement with receiving the service.

First Date of Service offered to Member: _____

Admission Guidelines

☐ Age ≥ 18 (Required)

☐ Primary SUD Diagnosis: _____

☐ Member chooses to receive Certified Recovery Specialist services