PerformCARE®

Mobile MH/ID Prior Authorization Request Form

CABHC Counties only

Member Name: _____

DOB: _____ MAID# (10 digits): _____

Provider Name: _____

Person Completing Form: _____ Contact Number: _____

Release of Information for PerformCare: ☐ Yes ☐ No

Check One: ☐ Initial ☐ Reauthorization **Requested Start Date**: _____

Code	Modifier	Service Description	Units	Place of Service
H0039	UB	Mobile MH/ID	15 min / 540 Units	99 (Other)

Current Diagnoses: _____

Member must meet all of the criteria indicated below:

☐ **18 years or older** ☐ **Serious Mental Illness diagnosis** ☐ **IDD Diagnosis**

☐ **Current community-based psychiatric provider (psychiatrist/CRNP)?**

Prescriber's Name: _____ Contact number: _____

☐ **Current County MH TCM, Admin or ID SC**

Provider Name: _____

Assigned TCM/Admin/ID SD: _____ Contact Number: _____

☐ **Frequent emergency room use, crisis services, and law enforcement involvement and/or inpatient psychiatric hospitalizations. Member is at risk of losing current housing support. Member is experiencing significant emotional distress and is having significant difficulty with behavioral and/or psychiatric challenges as identified by Member, his/her family and/or his/her provider agency. Explain/provide details below:**