PerformCARE®

Child/Adolescent Services

Family Based Mental Health Services Recommendation Letter

Member's Name: _____ MAID#: _____ Sex: _____

DOB: _____ Address: _____

Phone #: _____

Member County:

☐ Bedford ☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry ☐ Somerset

Determination of eligibility (all criteria must be met)

☐ One adult member agrees to participate in FBMH Services treatment.

☐ The child is at risk for out of home placement; or,

- ☐ If initial request returning form residential placement; or
- ☐ If initial request stepping down from inpatient stay.

☐ The child has a mental illness or emotional disturbance. Please indicate if known_____.

☐ The child serving systems involved with this child are in agreement with a request for FBMH services.

Recommendation:

☐ I recommend Family Based Mental Health Services for the above mentioned child and his/her family.

Signature of Prescriber: _____ Date: _____

Printed Name of Prescriber: _____

Address line 1: _____ State: _____

Address line 2: _____ Zip: _____

City: _____ Prescriber's phone number: _____

Please indicate professional title:

Licensed Psychiatrist Licensed Psychologist Licensed Physician

MA Provider ID: _____ Provider NPI#: _____

(Please enter the 9-digit MA Provider #)

All aspects of this form need completed or the request will not be accepted as a complete request for medical necessity review by PerformCare.