PerformCARE®

Music Therapy Authorization Request 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.**

Release of Information for PerformCare: ☐ Yes ☐ No

Member Information

Member Name: _____ MAID: _____

Referral Source: _____

DOB: _____ (***Music Therapy is available for members under 21 years of age)***

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

Therapist Name (including credentials): _____

Provider Name for Authorization: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Provider Contact: _____

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Authorization

☐ Initial ☐ Continued Stay

☐ Individual Therapy (G0176)

☐ Group Therapy (G0176 TT)

Start Date Requested: _____

Note: Updated treatment plans, progress notes, objective measures that have been utilized and all other treatment updates must be included for all continued service requests.

Rational for Music Therapy (must include Member's behavioral health needs to be addressed by music therapy)

Current DSM Diagnoses: _____

Danger to Self or Others? ☐ Yes ☐ No

If yes, explain: _____

Current Treatment (other than Music Therapy):

Service	Agency Name

Comments:

Target Discharge Date: _____

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Discharge Date: _____

Discharge Plan: