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Peer Support 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.**

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: _____)

** Recovery-focused individual service plan must be attached for all continued stay requests

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

☐ Forensic Peer Support Services (HX modifier)

☐ Youth Peer Support Services (HA modifier)

☐ Group Peer Support Services (U6 modifier) ** – please provide additional information below:

Current Individual Peer Support Service Authorization #: _____

Current Individual Peer Support Service Authorization End Date: _____

*** There must be an open Individual Peer Support Service authorization PRIOR to requesting Group Peer Support Services. Group Peer Support Services cannot be requested with an initial Peer Support Service request.*

Referral Complete Date (Start Date of authorization): _____

First Date of Service offered to Member: _____

Face-to-face or phone can be used for initial billable contact.

Admission Guidelines

Reason for Referral: ☐ Educational ☐ Vocational ☐ Social ☐ Self-Maintenance (Initial only)

Check all that apply. (A, B, C are required for Initial requests and A, B, C , D are required for reauthorization)

A. ☐ Age 14-17 years old ☐ Age > 18 years old

B. ☐ Member chooses to receive Peer Support Services (choice form on file with provider required)

C. ☐ Presence/history of serious mental illness (SMI) or Serious Emotional Disturbance.

C.1. ☐ List diagnosis:

C.2. ☐ List presenting problems:

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D. ☐ ** Functional impairment – difficulties that substantially interfere with/limit (check all that apply)

D.1. ☐ Unable to achieve or maintain one or more developmentally appropriate social/behavioral/cognitive/communicative/adaptive skills

D.2. ☐ Role functioning in one or more major life activities including basic daily living skills (i.e. eating, bathing, dressing, etc.)

D.3 ☐ Functioning in social, family, and/or vocational/educational contexts

D.4 ☐ Instrumental living skills (i.e. maintaining a household, managing money, getting around the community, taking medication)

** Section D is required for reauthorization requests ONLY

Describe functional impairment:

Prescriber Name: _____ Date: _____

☐ Physician ☐ Psychologist ☐ Physician Assistant ☐ LCSW ☐ LPC ☐ LMFT