PerformCARE®

Mobile Psychiatric Nursing Authorization Request Form

Submit within 10 calendar days of requested authorization start date

****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 #: _____

Provider Fax #: _____ Person Completing Form:_____

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Diagnosis

Diagnosis Codes (list primary first): _____

Check if applicable:

☐ MH/SU Co-Occurring Disorder

☐ MH/ID Dual Diagnosis

Authorization

Note: CPT Code = H0031 UB

☐ Initial Authorization = 6 mos (120 units – 15 mins/unit)

☐ Reauthorization = 6 mos (120 units - 15 mins/unit)

Staff Name (include credentials): _____