

Crisis Intervention Follow-Up Request Form

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When complete, please fax to 1-855-301-5356.

All out-of-network provider requests will be reviewed for medical necessity of services.

Crisis intervention follow-up services require **prior** authorization.

Please print clearly — incomplete or illegible forms will delay processing.

Member Information

Member name:					
Member date of birth:			Member ID number	:	
Legal guardian:					
Member primary diagnosis	5:				
Provider Information					
Provider name:			NPI number	;	
Group/agency name:			Phone	;	
Physical address:			Fax	;	
The provider is:	In network		Out of network	In credentialing pro	ocess
Provider credentials:	M.D.	Ph.D.	L.M.H.P.	Bachelor's level	N.P.
	Other:				
Provider contact name:					

Please complete the **Service Information** section of the form on page 2.

Initial Crisis Intervention Notification Request Form

Service Information						
Dates of service:						
Place of service: H	lome School	Other:				
When did the initial cr	isis occur?					
Explain/give an overv	ew of what the initia	l crisis involved: _				
All expected participa	nts in the crisis interv	ention follow-up	o sessions:			
			ompleted:			
,	, -,,					
Authorization request service. Crisis interver the crisis. Episodes ca	: Please note crisis in ntion follow up can oi nnot exceed 14 days	tervention follow nly be authorized . If a member has	v up is authorized following an initial crisis intervention If for up to 66 hours per episode or until the resolution of another crisis within seven calendar days of a previous and a new episode will not be allowed.			
Service code:	Dates of	service:	Units requested:			
I certify that I have received crisis intervention follow-up services. I understand payment will be from federal, state, and local funds. These are sometimes called public funds. I also understand that if I conceal facts or make false claims, statements, or documents, I may be prosecuted. By signing below, I agree that I (or my child) have received these services.						
Member/legal guardian signature:			Date:			
Member and/or leg	gal guardian declined					
Member and/or leg	gal guardian unable to	sign the encoun	nter form due to:			
Provider signature: _			Date:			

If you have any questions please contact Behavioral Health Utilization Management at **1-855-285-7466**.