MOLINA® HEALTHCARE

FAX #: 866-879-4742

ASSERTIVE COMMUNITY TREATMENT (ACT)
Cover Sheet

Member Information

Member Name:_________________________________ Member DOB:_____________________

Member ID # : _________________________________ Admission Date: ___________________

Provider Information

Provider/Facility Name: ____

Address: ____

NPI #: ____________________________________ TIN #: ___________________________

Attending Psychiatrist Name: ____

Contact Name (If Questions): ____

Contact Phone #: ____

ICD-10 Diagnosis: ____

Service Request

_______________________ Number of Months

_______________________ Total Number of Units

*** Please attach the Screening/Admission note including reason for referral; immediate clinical/other service needs; admission diagnoses (Axis I and Axis II)**