Behavioral Health Comprehensive Community Supports Authorization Request Form

Code : H2015

Member Information

Member Name:	Member Medicaid ID#:
Member Date of Birth:	

Provider Information

Treating Provider Name:	Provider NPI:	Provider TIN:
Requestor Information:		
Name:	Phone:	Fax:
Facility Name:	Facility NPI:	

Dates of Service for the Service being Requested		Service
Start Date:		
End Date:		

Diagnosis	
ICD10	**Description**

Severity = Mild, Moderate, Severe or N/A (Provide a brief description) OR you may submit the Member's biopsychosocial assessment

	Severity	Description
Psychiatric, behavioral or other co-morbid conditions		
Dysfunctions in daily living		
Risk of imminent danger to self or others		

PASSPORT BY MOLINA HEALTHCARE

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Additional Information

Indicate Social Determinants of Health

Treatment Plan

This may be left blank if you are submitting the actual treatment plan

To submit your request to the UM Department :

- **UTILIZE AVAILITY TO SUBMIT YOUR REQUEST**
- **FAX THE CLINICAL REQUEST TO: (833) 454-0641**
- **CALL THE REQUEST: (800) 578-0775**

You may also utilize the Universal Fax form located on our Website