# Behavioral Health TCM Authorization Request Form

**Code : T2023**

**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: |

**Are services court ordered:** ☐ **Yes** ☐ **No**

**Details if yes:**

| **Dates of Service for the Request Period** | |
|---|---|
| Start Date: | |
| End Date: | |

| **Diagnosis** | | **Indicate: SMI, SED,SUD or Complex/Chronic** |
|---|---|---|
| **ICD10** | **Description** | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Assessment Scores (if applicable)** | |
|---|---|
| ASAM (Level or dimensions?) | |

# Behavioral Health TCM Authorization Request Form

| TCM Care Plan Goals / Interventions |
|---|
| |

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

| What will TCM services address ? |
|---|
| |

| Response to services (Progress or Lack of Progress) (Concurrent review only) |
|---|
| |

**Indicate: 0=None; 1 = Mild; 2 = Moderate; 3 = Severe; N/A = Not Assessed for Request & provide a brief description**

| Category | Score | Description |
|---|---|---|
| Risk of Self Harm | 0 1 2 3 N/A | |
| Functional Status / ADLs | 0 1 2 3 N/A | |
| Medical Comorbidities | 0 1 2 3 N/A | |
| Environmental stressors/SDOH Needs | 0 1 2 3 N/A | |
| Support System | 0 1 2 3 N/A | |
| Response to Treatment (N/A for initial request) | 0 1 2 3 N/A | |

**What is the discharge or expected discharge date:**

**Please submit the Member's biopsychosocial assessment/re-assessment with your request.**

**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**