MOLINA HEALTHCARE

PLEASE FAX REQUEST TO 866-879-4742

Children's CFTSS Services
Notification of Service/Request for Concurrent Authorization

Please complete the following and attach this cover sheet to the Treatment Plan. Please include all relevant progress notes.

☐ Initial Service ☐ Concurrent Authorization Request

Member Information:

Member Name: _____ DOB: _____

Member ID#: _____ PCP: _____

Guardian: _____ Contact info: _____

Health Home Care Manager: _____ Phone #: _____

Diagnoses (ICD-10 codes and descriptions): _____

Provider Information:

Provider/ Agency Name: _____

Contact Name (if questions on request or treatment plan): _____

Site Address: _____

Provider NPI: _____ Phone Number: _____

Service	HCPCS code	Time per day (min/hour)	Days per week	Individual or Group	Onsite or Offsite
Community Psychiatric Support and Treatment (CPST)					
Psychosocial Rehabilitation (PSR)					
Other Licensed Practitioner (OLP)					
Family Peer Support Services (FPSS)					
Youth Peer Support Services (YPSS)					

Requesting: _____

Time frame: Start date: _____ End date: _____

Date of Initial Assessment: _____

Member Original Treatment Plan Date: _____

Date of Most Recent Treatment Plan Update: _____