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: _____

Member ID#: _____ DOB: _____

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)					

Requesting:

Time frame: Start date: _____ End date: _____

Date of Initial Assessment: _____

Member Original Treatment Plan Date: _____

Date of Most Recent Treatment Plan Update: _____