Florida Medicaid and Healthy Kids Behavioral Health Services Request Form
FOR: Intensive Outpatient and Routine Outpatient Therapy Services

NOTE: Routine OP Therapy can be requested on PSR/TBOS/TCM/Day Services form if Provider is also requesting any of those services

Please submit completed form via fax to: 1-855-713-0587

☐	**Standard Request**	Requests for prior authorization (with supporting clinical information and documentation) should be sent to the Health Plan at least 7 days prior to the date the requested services will be performed.
☐	**Expedited Request**	***Can only be requested with physician signature.*** By signing below, I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Physician Signature Validating Expedited Request _____ Date Signed _____

Service Type Requested	*List REV/CPT/HCPCS Code(s)*	*Number of Units of Each Requested*
Intensive Outpatient (IOP)		
Traditional Outpatient Individual/Family/Group Therapy		

Service Request Start Date:	**Service Request End Date**

MEMBER INFORMATION

Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**WellCare ID Number**		**Gender**	☐ **Female** ☐ **Male**
Third Party Insurance?	☐ **Yes** ☐ **No**	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type, and number.			
PRIMARY DIAGNOSIS:					

AGENCY PROVIDERS: FILL THIS SECTION OUT

Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

INDIVIDUAL PRACTITIONERS: FILL THIS SECTION OUT

Last Name		**First Name**		**NPI Number**	
WellCare ID Number		**Participating**	☐ **Yes** ☐ **No**	**Discipline/ Specialty**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

	Rationale for Request
1	**Describe in detail the specific presenting symptoms**
2	**Describe the member's risk of harm to self/others**
3	**Is the member at risk of legal intervention or out-of-home placement? Describe**

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4	**Has there been any prior inpatient, outpatient or IOP treatment? ☐ Yes ☐ No (If yes, please specify the type and the dates).**
5	**How did member respond to prior treatment (e.g., what worked/did not work, barriers to completing treatment)**
6	**What are the environmental/community stressors and/or supports that contribute to the member's clinical status (positively or negatively)?**
7	**Describe the member's behaviors and reactions to their symptoms and stressors (e.g. impact on daily functioning/work/school)**
8	**What treatment goals are being/or will be addressed in therapy?**
9	**For continuing therapy: Describe specific indications of the member's improvement and progress toward the treatment plan goals as a result for the services** **(*Provider may attach recent progress notes)**
10	**Is the member on psychotropic medication and/or seeing a psychiatrist? (List medications, if applicable)**
11	**Does the member have co-morbid medical issues or substance abuse issues? Describe:**

Primary Diagnoses		**R/O**	
Secondary Diagnoses		**R/O**	
Medical Problems			
***Current Functional Assessment Score**		**Highest Functional Assessment Score in Past Year**	

***FOR IOP, attach a copy of the FARS/CFARS if available**

Please Note: ADDITIONAL INFORMATION MAY BE REQUESTED