

PRIME DX

MENTAL HEALTH SERVICES PRE-AUTHORIZATION REQUEST FORM
ONLY ONE REQUEST PER FORM PLEASE
FOR MONTGOMERY COUNTY HOSPITAL DISTRICT HCAPCLIENTS ONLY

Please complete and submit all requested information
****Please provide a 72 hour notification prior to date of service****

Patient/Client Name _____ DOB _____ Male Female
ID# _____ Group # _____

Ordering Physician:

Full Name _____
Contact Person _____
Address _____
Phone _____ Fax _____
Tax ID _____

Hospital/Facility/Specialist Providing Services:

Name _____
Address _____
Phone _____ Fax _____
Tax ID _____

Please complete the following:

- 1) Patient's DSM-III-R/DSM-IV diagnosis: _____
- 2) Treatment Plan; check all modalities to be used:
___ Individual Therapy-90806 ___ Group Therapy-90853
___ Family Therapy-90847
___ Psychopharmachotherapy 90805/90807
___ Other _____
- 3) Current psychotherapeutic medications and dosages: _____

- 4) Additional remarks to justify need for further treatment: _____

- 5) Number of additional visits requested: _____
- 6) Frequency of visits: ___ Weekly ___ Bi-weekly ___ Monthly ___ PRN

Signature of Provider: _____

Please provide the following information along with this form:

- Patient's History and Physical
- Patient's clinic records/medical records pertinent to the request
- Previous treatment, including meds, therapy and response to treatment.
- Diagnostic testing performed including the results.

*****FAX REQUEST TO (800) 213-5108*****

Preauthorization number _____ Approved by _____
Valid from _____ to _____
Approved # of visits _____ Approved # of days _____

PLEASE CALL BOON-CHAPMAN AT 800-213-7524 FOR BENEFITS, ELIGIBILITY, EXCLUSIONS, AND LIMITATIONS. ELIGIBILITY SHOULD BE RECHECKED ON THE DATE OF SERVICE. THIS AUTHORIZATION DOES NOT GUARANTEE ELIGIBILITY OR BENEFITS.

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

Health Care Information is personal and sensitive information related to a person's health care. It is being faxed to you after appropriate authorization from the patient/member or under circumstances that do not require patient/member authorization. You, the recipient, are obligated to maintain the health care information in a safe, secure and confidential manner. Re-disclosure of the health care information transmitted without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.