

# BEHAVIORAL HEALTH INFORMATION



FIRST COAST ADVANTAGE  
PROVIDER INSERVICE

May 14, 15, 16, 2008

**PRE-AUTHORIZATION  
BEHAVIORAL HEALTH SERVICES FORM**

Please return by fax to: (904) 244-9740  
**Attention: Behavioral Health Coordinator**  
Call (904) 244-9780 or 244-9197 with questions

**Please print clearly.**

Today's Date: \_\_\_\_\_ Admit Date: \_\_\_\_\_

Member Name: \_\_\_\_\_ SS #: \_\_\_\_\_ DOB: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Member Home Phone: \_\_\_\_\_

Agency/Center: \_\_\_\_\_ Location: \_\_\_\_\_

Member is: New to Services \_\_\_ Established \_\_\_ FARS/CFARS at admission: \_\_\_\_\_

ICD-9 Code(s) & Descriptions: \_\_\_\_\_  
\_\_\_\_\_

Services to be Billed (circle all that apply): Inpatient admission      Med Management

Case Management      Intensive Case Management      Outpatient Individual/Family Counseling

Outpatient Group Counseling      Psychosocial Rehabilitation

Other: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Phone Number: \_\_\_\_\_

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\*For Billing or Claims Submission Information, Please call APEX Benefit Services: (866) 270-2468

**THIS SECTION IS TO BE COMPLETED BY BEHAVIORAL HEALTH COORDINATOR**

Submitted telephonically \_\_\_\_\_ Received Date & Time: \_\_\_\_\_

FACT consumer \_\_\_\_\_ Case Management Services \_\_\_\_\_

FARS/CFARS at discharge from services: \_\_\_\_\_ Rater: \_\_\_\_\_



## REQUEST FOR ADDITIONAL UNITS BEHAVIORAL HEALTH SERVICES FORM

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Today's Date: \_\_\_\_\_ Admit Date: \_\_\_\_\_ Member Name: \_\_\_\_\_

SS #: \_\_\_\_\_ DOB: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Original Authorization Number: \_\_\_\_\_

Agency/Center: \_\_\_\_\_ Location: \_\_\_\_\_

**Services to be provided with additional units: (Circle all that apply)**

Medication Management      Case Management      Intensive Case Management

Individual/Family Counseling      Group Counseling      Psychosocial Rehabilitation

Other \_\_\_\_\_

**Provider Name:** \_\_\_\_\_ **Provider Phone Number:** \_\_\_\_\_

Clinical Justification for additional units: \_\_\_\_\_

**Please attach a copy of the most recent FARS/CFARS. Current Diagnosis:** \_\_\_\_\_

**If member is receiving Psychosocial Rehabilitation, please answer the following in detail:**

1. How are the member's needs being met through psych. rehab? \_\_\_\_\_

2. How often is the member attending and how is this frequency justified? \_\_\_\_\_

3. Describe the member's progress over the past six months and explain how further services will benefit the member: \_\_\_\_\_

\_\_\_\_ Units       Approved       Denied       Additional information needed

**New authorization #:** \_\_\_\_\_

**Approved Services:** Case Management      Intensive Case Management      Med. Management

Individual/Family Counseling      Group Counseling      Psychosocial Rehabilitation

Other Services: \_\_\_\_\_