Behavioral Health Outpatient Service Request Form

Fax to: 616.975.0249 *Incomplete or missing information may result in a processing delay.

Member information

Last name _____ First name _____

Priority Health ID #_____ Date of birth _____

Type of request

☐ TMS ☐ ADD/ADHD testing ☐ Psychiatric ☐ Psych testing ☐ Therapy
☐ Substance use disorder- Intensive outpatient ☐ Medicare organization determination

Treatment provider name_____Provider tax ID _____

Treatment setting: ☐ Office ☐ FQHC-Federally Qualified Health Center ☐ Clinic/Facility

☐ Other _____

Group/facility name _____

Service address _____

Note: Authorization for FQHCs/Clinic/Facility will be entered to the Group/ Facility name provided above. All other services will be authorized to the treatment provider name indicated above.

TMS requests- clinical record must be faxed with this form.
Substance Use Disorder- Intensive outpatient concurrent reviews, clinical record must be faxed with this form.

What is/are the specific mental health issue/s being addressed? ICD-10 (if known)

☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Other (Please describe)

_____

Any presence of the following?

☐ Suicidal thoughts ☐ Homicidal thoughts ☐ Psychosis ☐ Drug or alcohol withdrawal symptoms

Any current behavioral health services being received through Community Mental Health? ☐ No ☐ Yes

If yes, please specify: _____

Any hospitalization in a psychiatric setting within the past two years?

☐ Yes ☐ No

Contact information of office administrator requesting the authorization:

Name _____

Address _____

Phone _____ Fax:_____

Comments: