

Crisis Intervention Services

Retrospective authorization requests for crisis intervention services must be submitted within 7 calendar days of the date of service. Service is limited to a maximum of 3 occurrences in a 90-day period (see MSM Chapter 400).

Fax this request to: (866) 480-9903

For **questions** regarding this form, call: (800) 525-2395

DATE OF REQUEST: ____ / ____ / ____

RECIPIENT INFORMATION					
Recipient Name:					
Recipient ID:				Date of Birth:	
PROVIDER INFORMATION <i>(provider must be a QMHP)</i>					
Provider Name:			NPI:		
Fax:			Phone:		
SERVICE DETAIL AND DIAGNOSIS CODE					
Axis I Primary Code:		Narrative:			
Describe recipient's behavior that required immediate, intensive intervention:					
Specify the level of risk (includes danger to self and/or others) and describe services provided:					
SERVICE REQUESTED <i>The requester will be deemed the point of contact for this authorization request and is responsible for dissemination of all information regarding this request.</i>					
Code	Modifier	Date(s) Services Provided	Units per Day	Days per Week	Total Units
1					
2					
3					
Provider Signature:			Date:		

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.