

Initial Behavioral Health Service Request Form

<Please Submit to the Dedicated Contract Fax Line Below>

Medicare	Medicaid
Arizona- 888-834-8404 Missouri- 855-710-0162 Arkansas – 855-710-0160 New Jersey- 888-339-2677 Connecticut- 888-365-5607 New York- 855-713-0589 Georgia- 855-710-0166 Ohio- 855-710-0164	Illinois- 855-713-0593 South Carolina - 855-710-0160 Kentucky- 888-365-5676 Tennessee - 855-710-0160 Louisiana- 855-710-0160 Texas- 855-671-0259 Mississippi - 855-710-0160 Florida- 855-710-0168

<input type="checkbox"/>	Initial Service Request	The services identified below can be registered without a clinical review once per member. Initial service requests should be sent to the Health Plan fourteen (14) days prior to the date the requested services will be performed. If your request for services are denied using this process it means that the initial service set is already in use and you will need to revert to a Prior Authorization Request.
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***All NON-Participating providers must submit outpatient service request using the Routine Outpatient Service Request Form.**

MEMBER INFORMATION

Last Name		First Name, Middle Initial		Date of Birth	
Phone Number		WellCare ID Number		Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male

FOR INDIVIDUAL PROVIDERS: TREATING PROVIDER/PRACTITIONER INFORMATION

Last Name		First Name		NPI Number	
WellCare ID Number		Participating	<input type="checkbox"/> Yes <input type="checkbox"/> No	Discipline/Specialty	
Street Address		City, State		Zip	
Phone Number		Fax Number		Office Contact	

CMHC/ FACILITY INFORMATION (use instead of above)

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

REQUESTED SERVICES

The following services may be registered upon request. One set of registered services are allowed per member annually.

Requested start date:		
<i>Initial Service Set</i>	<u>9000-series codes</u> You will receive 20 sessions that include any/all of the following (they are not registered separately- you can bill for up to 20 total including all the below)	Submission of this form is your agreement to accept the sessions/units indicated. All further outpatient services on this form that you wish to provide within the year must be requested using the Prior Authorization process.
	<input type="checkbox"/> Check here if you wish these to be registered 90832, 90834, 90837, 90846, 90847, 90849, 90853, 90887	