MI HealthLink Initial Authorization Request Form

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| **Provider Agency** |  | **Contact Person** |  | **Provider Phone Number** |  |
| **Date Requested** |  | **MHL Eligibility Month** |  | **Start Date of Services** |  |
| **Member Name** |  | **Date of Birth** |  | **Member Phone Number** |  |

***Services/Codes (Please refer to your contract for codes that can be requested by your agency)***

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| 90792 - Psych Diagnostic with med services 99201/99202 - New pt, Med Review 99212/99213/99214 - Current Pt, Med Review96372 - Med Injection | 90791 - Psych Diagnostic no med service 90832/90834/90837 - Individual Therapy 90853 - Group, Adult or Child90847 - Family Therapy per Session | 96101 - Assessment BHT/ABAQ3014 - Telemedicine Facility Fee |

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| **Service/Code Requested** | **Start Date** | **End Date** | **Number of Units** |
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**Documents Required for Processing Psychiatric Service Requests** **Documents Required for Processing Therapy Service Requests**

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| **Attached** | **Previously Provided** | **Document** |
| ☐ | ☐ | Release of Information (MDCH Form-2 pages) |
| ☐ | ☐ | Psychiatric Evaluation |
| ☐ | ☐ | Med Review Notes |
| ☐ | ☐ | Treatment Plan for requested dates of service |

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| **Attached** | **Previously Provided** | **Document** |
| ☐ | ☐ | Release of Information (MDCH Form-all 4 pages) |
| ☐ | ☐ | Assessment |
| ☐ | ☐ | Treatment Plan for requested dates of service |
| ☐ | ☐ | Progress Notes |

***Fax this request, along with the required documents to: (269) 441-1234 or secure e-mail to*** ***Beth.Guisinger@swmbh.org*** ***and*** ***Leah.Mitchell@swmbh.org***

*If you have questions regarding MI HealthLink authorizations, please feel free to contact* ***(269) 488-6849.***