

Please type or print clearly. Incomplete and illegible forms will delay processing.

When complete, please fax to:

Please use the fax number listed below that corresponds to the state where the AmeriHealth Caritas VIP Care plan operates.

Delaware	Florida	Louisiana	Michigan	North Carolina	Pennsylvania
1-866-329-3324	1-833-329-3524	1-866-565-2583	1-855-329-6400	1-833-362-7262	1-855-396-5750

Prior authorization is required for outpatient services. For psychological and neurological testing, please submit the Testing Outpatient Request Form.

Electroconvulsive therapy (ECT) services must have prior authorization by telephonic review. Please call :

Please use the phone number listed below that corresponds to the state where the AmeriHealth Caritas VIP Care plan operates.

Delaware	Florida	Louisiana	Michigan	North Carolina	Pennsylvania
1-833-727-3301	1-833-727-3598	1-855-330-2111	1-844-464-2255	1-855-330-2999	1-866-588-0219

Out-of-network providers: Prior authorization and a non-contracted provider form are required for all services.

Member information

Member name:	Member ID number:
Social Security number:	Date of birth:
Member address:	
City, state, ZIP code:	Phone:
Who referred member for treatment? <input type="checkbox"/> Self <input type="checkbox"/> Primary care provider (PCP) <input type="checkbox"/> State agency <input type="checkbox"/> Other: _____	
Name of referring agency:	Phone:

Treating provider information

Name (with credentials):	<input type="checkbox"/> NPI : _____ <input type="checkbox"/> In network <input type="checkbox"/> Out of network <input type="checkbox"/> In credentialing process
Phone:	Fax:
Address:	City, state, ZIP code:
Group name/number:	Contact name:
Treating provider signature:	

Reason for services

Primary reason or complaint:	Start date requested:
Service codes requested:	Frequency:

DSM diagnosis

List all Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses (behavioral health and medical).



Supports and care coordination

- 1. Is the member currently participating in any vocational services? Yes No
- 2. Is the member's family or supports involved in treatment? Yes No
- 3. Has the member been evaluated by a psychiatrist? Yes No
- 4. Is there coordination with other substance use providers? Yes No
- 5. Is there coordination of care with other behavioral health providers? Yes No
- 6. Is there coordination of care with medical providers? Yes No

Medications

Is member on prescribed medication? Yes No Is member compliant with medication? Yes No

Prescribing providers:

Medications and dosages:

Please attach the current treatment plan. Include documentation related to progress on goals and any changes made as a result.

Additional comments