

Mental Health Center of Dane County, Inc.

SERVICE INITIATION FORM

WITHIN 7 CALENDAR DAYS OF INITIAL APPOINTMENT, providers must submit service authorization initiation forms to the Mental Health Center Utilization Management Program Care Facilitator by FAX at (608) 280-2707 or by mailing the completed form to: MHCDC, UMP Care Facilitator, 625 West Washington Avenue, Madison WI 53703.

Questions may be directed to the Care Facilitator at (608) 280-2702.

MEMBER INFORMATION		
<i>Name — (Last, First, Middle Initial)</i>		<i>Date of Birth</i>
<i>NPI/Medicaid ID Number</i>		
PROVIDER INFORMATION		
<i>Clinician Name</i>		<i>Practice/Group/Vendor</i>
<i>Telephone # & Extension</i>	<i>FAX #</i>	<i>Clinician's Billing Credentials</i> <input type="checkbox"/> Bachelors (HN) <input type="checkbox"/> Masters (HO) <input type="checkbox"/> PhD Psychologist (HP) <input type="checkbox"/> APNP (UB) <input type="checkbox"/> Phys Asst (U8) <input type="checkbox"/> MD (UA)

SERVICES REQUESTED		
<i>Date of Initial Appointment:</i> _____		
<p>Service Type 1: Quantity of 1.0 session = 1 hour <input type="checkbox"/> Individual Psychotherapy 90806 <input type="checkbox"/> Psych Diag Interview..... 90801 <input type="checkbox"/> Family Psych – w/o patient 90846 <input type="checkbox"/> Family Psych – w/ patient 90847 <input type="checkbox"/> Multi Family Group 90849 <input type="checkbox"/> AoDA Group H0005 <input type="checkbox"/> AoDA Individual H0022 <input type="checkbox"/> AoDA Family/Couple..... T1006</p> <p>Quantity of 1.0 session = 15 minutes <input type="checkbox"/> Pharmacologic Mgmt 90862 <input type="checkbox"/> Other (give description & procedure code)</p>	<p>Service Type 2: Quantity of 1.0 session = 1 hour <input type="checkbox"/> Individual Psychotherapy 90806 <input type="checkbox"/> Psych Diag Interview 90801 <input type="checkbox"/> Family Psych – w/o patient 90846 <input type="checkbox"/> Family Psych – w/ patient 90847 <input type="checkbox"/> Multi Family Group 90849 <input type="checkbox"/> AoDA Group H0005 <input type="checkbox"/> AoDA Individual H0022 <input type="checkbox"/> AoDA Family/Couple T1006</p> <p>Quantity of 1.0 session = 15 minutes <input type="checkbox"/> Pharmacologic Mgmt 90862 <input type="checkbox"/> Other (give description & procedure code)</p>	<p>Service Type 3: Quantity of 1.0 session = 1 hour <input type="checkbox"/> Individual Psychotherapy 90806 <input type="checkbox"/> Psych Diag Interview..... 90801 <input type="checkbox"/> Family Psych – w/o patient 90846 <input type="checkbox"/> Family Psych – w/ patient 90847 <input type="checkbox"/> Multi Family Group 90849 <input type="checkbox"/> AoDA Group H0005 <input type="checkbox"/> AoDA Individual H0022 <input type="checkbox"/> AoDA Family/Couple..... T1006</p> <p>Quantity of 1.0 session = 15 minutes <input type="checkbox"/> Pharmacologic Mgmt 90862 <input type="checkbox"/> Other (give description & procedure code)</p>
<i>Frequency of Sessions</i> (e.g., monthly, bimonthly, weekly, etc.):	<i>Frequency of Sessions</i> (e.g., monthly, bimonthly, weekly, etc.):	<i>Frequency of Sessions</i> (e.g., monthly, bimonthly, weekly, etc.):

PROVIDER SIGNATURE

Date Signed:

MHCDC Use Only	
Date Received	Date response sent to provider
Staff initials	Staff initials