

SUBMIT TO

Utilization Management Department
PHONE 844-289-2264 | FAX 844-989-0154

MOBILE CRISIS NOTIFICATION FORM

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

Date				
MEMBER INFORMATION		PROVIDER INFORMAT	TON	
Name		Provider Name (print)	Provider Name (print)	
DOB		Provider/Agency Tax ID	Provider/Agency Tax ID #	
Member ID #		Provider/Agency NPI Sub	Provider #	
		Phone	Fax	
CURRENT ICD DIAGNOSIS				
Primary		Has contact occurred w	rith family? 🗆 Yes 🗆 No	
Secondary				
Fertiary		Time of call by provider/	Time of call by provider/agency	
ditional		Time of assessment by pr	Time of assessment by provider/agency	
Additional		IP Appropriate Hospital	□ Yes □ No	
POSSIBLE BH CRISIS	Member identified an CARES is called	If Mobile Crisis appropriate, CARES dispatch to MCR team	MCR Responder arrives in 90 minute window	
IM-CAT and Crisis Safety Plan completed		Member is placed in a higher level of care Member is stabilized in the community	Provider can bill crisis intervention, crisis stabilization, and case management* for up to 30 days postcrisis event without prior authorization (*Case management requires prior authorization after 200 units)	
Clinician Signature	Date	 Clinician Signature	Date	

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PLEASE ATTACH IM - CAT and crisis stabilization plan