YouthCare HealthChoice Illinois

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

Name____

DOB ____

Member ID #____

PROVIDER INFORMATION

Provider Name (print) ________________________________

Provider/Agency Tax ID #______________________________

Provider/Agency NPI Sub Provider #_____________________

Phone ______________________ Fax ____________________

CURRENT ICD DIAGNOSIS

Primary ____

Secondary____

Tertiary ____

Additional ____

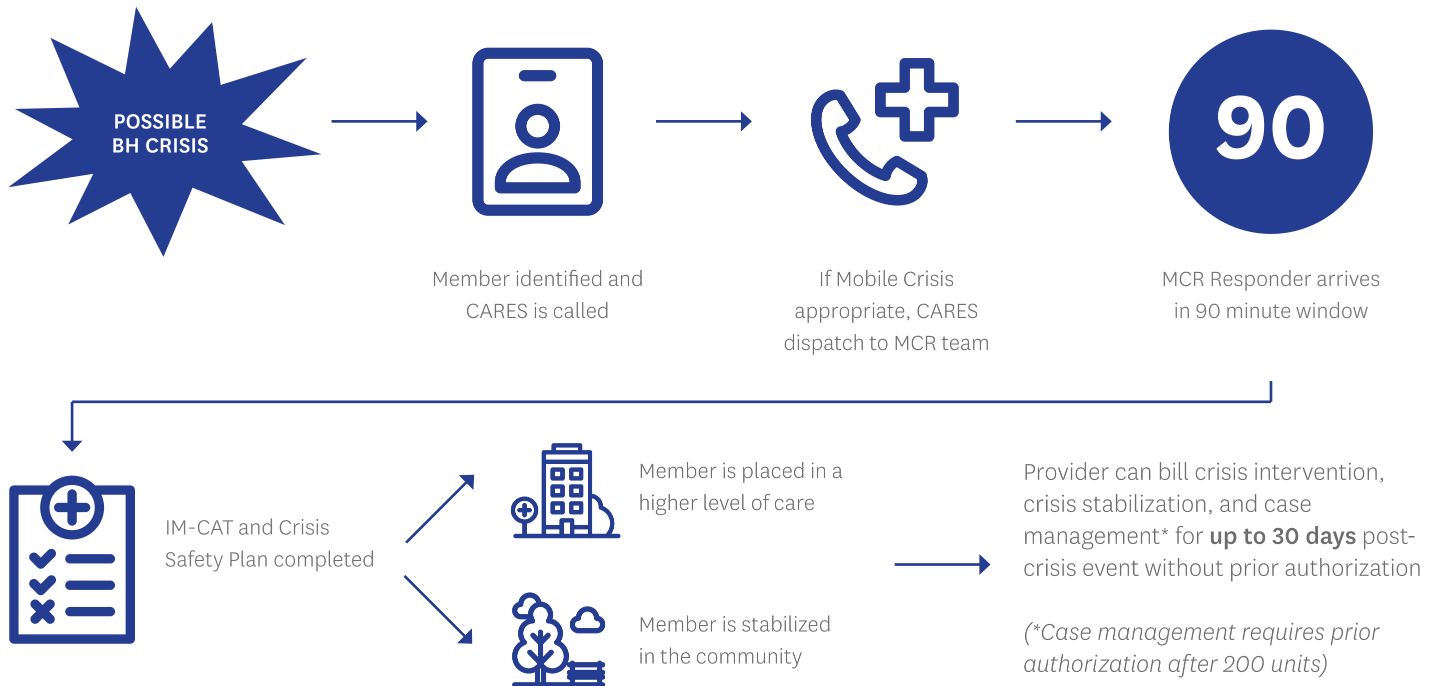
Additional ____

Has contact occurred with family? ☐ Yes ☐ No

Time of call by provider/agency___________________________

Time of assessment by provider/agency______________________

IP Appropriate Hospital ☐ Yes ☐ No



______________________________________ ______________________________________
Clinician Signature Date Clinician Signature Date

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PLEASE ATTACH IM – CAT and crisis stabilization plan