CARELON BEHAVIORAL HEALTH
MEDICATION MANAGEMENT REGISTRATION FORM

Prescribers need to complete this form when requesting Medication Management only.

For most efficient and timely service – use of authorization request flow on ProviderConnect is the preferred method of submitting requests. Faxed or mailed forms should only be submitted to the specific fax or address. Please confirm for a specific contract that forms are allowed. Some contracts allow only telephonic review if web service is not utilized. Some contracts require requests only be submitted via the web. Some contracts do not require authorization for medication management services.

If other outpatient services are being requested, please complete the Outpatient Review Form as appropriate.

PLEASE TYPE OR PRINT LEGIBLY. Check/circle response where applicable.

Request Start Date __/__/_____

Type of Service Requested: Mental Health Substance Abuse

Patient Name _____

Date of Birth: _____Age: _____

Address: (City/State only): _____Tel. #_____

Patient's Insurance ID#: _____

Patient's Employer/Benefit Plan: _____

Provider Name: _____

Provider: Program/Clinic: (if applicable)

Carelon Provider # (if known) _____

Service Address: _____

City/State/ZIP: _____

Is this also your mailing address? Yes No If not, please update below signature.

Are you independently licensed to provide services in the State where you are treating this patient? Yes No

ID# _____Check Which: SSN TaxID NPI

Diagnosis:

Behavioral DX (ICD code & Description): 1._____/_____

2._____/_____ 3._____/_____

Medical DX (ICD Code & Category: 1._____/_____

2._____/_____ 3._____/_____

Social Elements Impacting DX: 1._____ 2._____

Optional Functional Assessment: Tool: _____ Score:_____

Additional Info:_____

Requested Services:

Medication Management M0064 Wkly: Mnthly: Qtrly: Other:_____

Other:_____ Wkly: Mnthly: Qtrly: Other:_____

Other:_____ Wkly: Mnthly: Qtrly: Other:_____

Treating Provider's Signature:_____

Date:_____

Updated Mailing Address:_____

City/State/Zip:_____