



**MISSOURI CARE – BEHAVIORAL HEALTH SERVICES
MEDICATION MANAGEMENT REQUEST FORM (FOR OVER 8 UNITS)**

Please submit your request prior to providing services, or payment may be denied. In case of extension of/addition to an existing authorization, submit request two weeks before expiration. Fax to: Missouri Care – Behavioral Health Services, 866-543-2385, or call: 800-889-4073. Authorization is not a guarantee of payment; payment is based on a member's benefits and eligibility at time of services.

Patient's Name: _____ DOB _____ Member ID# _____

Requesting:

CPT Code	Frequency	#Of Visits Requested	End Date

Current Diagnosis [DSM] :

Axis I _____ Axis II _____ Axis III _____
 _____ Axis IV _____ Axis V ____ / ____

Psychotropic Medications:

Name	Dose (mg)	Frequency	Duration	Effective?

Other Medications:

Name	Dose (mg)	Frequency	Duration	Purpose

Date of Most Recent: Tx Plan _____ PCP Communication _____

Therapist Communication _____

Date of This Request: _____ Provider Name: _____

Provider ID # _____ Address: _____

Phone _____ Fax _____