

BEHAVIORAL HEALTH SERVICES

NOTIFICATION FORM

Provision of Outpatient Services



Please submit your notification **prior** to submitting claims. **Fax to:** Missouri Care - Behavioral Health Services, 1-866-543-2385

Date of Request: _____

Patient Name: _____ **Date of Birth:** _____ **Member ID#:** _____

Current Diagnosis [DSM-IV-TR] (if available):

Axis I: _____ Axis II: _____ Axis III: _____

Axis IV: _____ Axis V – Current: _____ Past Year: _____

Planned Services:

	<i>CPT Codes[s]</i>	<i>Frequency</i>	<i># of Units</i>	<i>Start Date</i>	<i>End Date</i>
Mental Health Tx					
Addictions Tx					
Medical Tx					
Other Services					

Provider Name: _____ **ID:** _____

Address: _____

Phone: _____ **Fax:** _____