FAMILY CARE REQUEST FOR PRIOR AUTHORIZATIONS
Mental Health Services at Jewish Family Services

Member Name: ______________________ **Today's Date:** ______________

Social Security Number: ______________ **Member D.O.B.** ______________

Address: ______________ **City:** ______________ **Zip:** ________

Phone: _____ - _____ - ________ **Alt. Phone:** _____ - _____ - ________ ☐ **Work** ☐ **Cell**

Does member have a guardian? ☐ Yes* ☐ No If Yes, type: ☐ Corporate ☐ Relative ☐ Volunteer ☐ Other: ________

Guardian's Name: ______________________ Phone: ______________

Address: ______________________ City: ____________ State: ______ Zip code: ________

*If member has a guardian, please fax the guardianship paperwork along with this referral form

Description of Member's Presenting Problem(s):

CMU Name:	**CMU Fax:**
Care Manager:	**Care Manager Phone:**

Authorization Number	Procedure Code	Description	Modifier Code	Number of Units	Unit Size	Frequency
	90791	MH Psych Diagnostic Interview	C36 HO	1	1 Hour	One Time Only
	99082	MH to Home Travel per 1 way**	C37 HN	2	1 way units	One Time Only

** Travel needs to be authorized for in-home services.

Authorization Start Date:	**Authorization End Date:**

Please fax completed form to Beth Shapiro at 414-225-1346

FOR JFS CLINIC USE ONLY	**Appointment date:**	**JFS Clinician:**

Revised 2.2015