

State of Maryland

PROVIDER REQUEST TO CSA FOR URGENT CARE FOR UNINSURED Form Dated 08/04/2010

(Form to be sent by Provider to the CSA for Approval)

CONSUMER NAME:		START DATE DESIRED:		DOB:		SSN:	
Address:							
INCOME: Annual Income: \$ Monthly Income: \$ Income Source: # of Dependents:				INSURANCE: PAC: (Application Date) MA: (Application Date) MEDICARE: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Clinical Indications for (Continued) Outpatient Services: Please check YES or NO							
Hx Suicide Attempts:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Dates/Details:					
Hx of Psychiatric Hospitalization:	<input type="checkbox"/> YES <input type="checkbox"/> NO	When/Where:					
Hx of Clinical Deterioration:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Explain:					
Hx of Arrests:	<input type="checkbox"/> YES <input type="checkbox"/> NO	When/Where:					
Psych. Dx:	<input type="checkbox"/> YES <input type="checkbox"/> NO	DSM IV: (if applicable)					
Explain Why Request is Urgent , What Else Has Been Tried; What Services Were Sought but Denied? Case Mgmt. – state specific reason(s)							
CSA and MHA Area Only (This shaded area is only for CSA and MHA use only)							
CSA USE ONLY Request for Case Mgmt. Exception		<input type="checkbox"/> Discharge from hospital <input type="checkbox"/> Release from incarceration <input type="checkbox"/> Diversion from hospital or jail <input type="checkbox"/> At risk of homelessness/homeless <input type="checkbox"/> NCR <input type="checkbox"/> Other:					
CSA Approves CM Exception <input type="checkbox"/> Yes <input type="checkbox"/> No		CSA Signature:		Date:			
FOR MHA USE ONLY: CASE MGMT. EXCEPTION REQUEST		<input type="checkbox"/> Penny Scrivens, MHA Email: pscrivens@dhmh.state.md.us <input type="checkbox"/> James Chambers, MHA Email: jchambers@dhmh.state.md.us				FAX #: (410)402.8304	
FOR MHA USE ONLY: APPROVAL/DENIAL OF CASE MGMT. EXCEPTION REQUEST		<input type="checkbox"/> APPROVED <input type="checkbox"/> NOT APPROVED Reason for Denial: <input type="checkbox"/> Ineligible Diagnosis <input type="checkbox"/> Exception Reason Not High Priority <input type="checkbox"/> MHA funds unavailable at this time <input type="checkbox"/> Refer consumer to other community service <input type="checkbox"/> Other: _____					
		MHA Signature: _____				Date: _____	
CSA Approves Reimbursement:		<input type="checkbox"/> Yes	<input type="checkbox"/> No	CSA Priority:		<input type="checkbox"/> Urgent	<input type="checkbox"/> High
CSA:	Phone Number:			*Fax Number:			Email:
Signature:				Date:			

** CSAs: Please put fax number on this form prior to faxing the form over to MHA to request Uninsured C/M Services approval **