South Carolina
Department of Health and Human Services
Mental Health Form

FILL OUT COMPLETELY TO AVOID DELAYS

Beneficiary Information	
Beneficiary's Name:	
Medicaid ID #:	
Date of Birth:	

Provider Information	
Individual NPI:	
Organization NPI:	
Service Location Address:	
City & State:	

DSM-IV TR Diagnosis

Axis I _ _ _ _ _/_ _ _ _ _/_ _ _ _ _ Axis II _ _ _ _ _/_ _ _ _ _ Axis III _ _ _ _ _/_ _ _ _ _

Date first seen: ___________ **Date of last service:** ______________ **# of additional visits requested:** _________

Current Clinical Information: (Circle each. Scale 0=None, 1=Mild, 2=Moderate, 3=Severe, 4=Extreme)

Aggression	0 1 2 3 4	Depressions	0 1 2 3 4	Relationship Problems	0 1 2 3 4
Alcohol/Substance Use	0 1 2 3 4	Hallucinations	0 1 2 3 4	Side Effects	0 1 2 3 4
Anxiety/Panic	0 1 2 3 4	Impulsivity	0 1 2 3 4	Sleep Effects	0 1 2 3 4
Appetite Disturbance	0 1 2 3 4	Job/School Problems	0 1 2 3 4	Sleep Disturbance	0 1 2 3 4
Attention/Concentration	0 1 2 3 4	Mania	0 1 2 3 4	Weight Loss	0 1 2 3 4
Deficit in ADLs	0 1 2 3 4	Medical Illness	0 1 2 3 4	Other	0 1 2 3 4
Delusions	0 1 2 3 4	Memory	0 1 2 3 4	Current Stressors	0 1 2 3 4

Services

- 90833
- 90836
- 90838
- 90846
- 90847
- 96101
- 90853
- 90832
- 90834
- 90837
- 96102

Current Medications		**Name**	**Dose**	**Frequency**	**Side Effects**
◇ **New**	**1.**				
◇ **New**	**2.**				
◇ **New**	**3.**				
◇ **New**	**4.**				
Compliance		◇ **>90%**	◇ **50-90%**	◇	**<50%**
Reasons for Noncompliance:					

_____________________________ (__)_____________ (__)_____________

Physician Name Phone: Fax

_____________________________ _____________

Physician Signature Date

Clinical documentation must be submitted with this request and submitted to the QIO using one of the following methods:
KePRO FAX#: 1-855-300-0082, KePRO Customer Service Phone#: 1-855-326-5216, KePRO website: http://scdhhs.Kepro.com.

Disclaimer: Authorization indicates that SCDHHS determined that medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the beneficiary's eligibility and benefit limitations at the time services are rendered. The Physician Assistant is not authorized to sign this form.

Behavioral Health Services
Post Office Box 8206
Columbia, South Carolina 29202-8206