



MANUAL	HHSC UNIFORM MANAGED CARE MANUAL	15.2	1 of 3
CHAPTER TITLE	Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Form	EFFECTIVE DATE	
		September 1, 2015	
		Version 2.4	

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	2.0	September 1, 2014	Initial version of Uniform Managed Care Manual Chapter 15.2, "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Form" Chapter 15.1 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, and 529-13-0042.
Revision	2.1	September 1, 2014	Form is reformatted for clarity.
Revision	2.2	October 15, 2014	Revision 2.2 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, and 529-13-0042; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.
Revision	2.3	March 1, 2015	Form is modified to add field for "Member Date of Birth" and to clarify the "Purpose of Form" explanation.
Cancellation	2.4	September 1, 2015	This chapter will be withdrawn effective January 1, 2016, and replaced by Chapter 15.4 "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Instructions".

¹ Status is represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

² Revisions are numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.

Targeted Case Management and Rehabilitative Services Request Form

Date of Completion of CANS / ANSA	
Dates of Service Requested	
Member Name	
Member Date of Birth	
Medicaid Identification Number	
Primary Diagnosis (if more than one primary diagnosis, enter up to 5 codes separated by commas)	
Purpose of Form (as defined by TRR guidelines)	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> Re-assessment
If Reassessment, specify result:	<input type="checkbox"/> Reduction in level of care <input type="checkbox"/> Increase in level of care <input type="checkbox"/> Continue Services at same Level of Care <input type="checkbox"/> Discontinuation of Services (no medical necessity)

Adult Clients	
Please indicate the recommended level of care generated from the CMBHS system.	Please indicate the provider requested level of care.
<input type="checkbox"/> Level of Care 0 <input type="checkbox"/> Level of Care 3 <input type="checkbox"/> Level of Care 1M <input type="checkbox"/> Level of Care 4 <input type="checkbox"/> Level of Care 1S <input type="checkbox"/> Level of Care 9 <input type="checkbox"/> Level of Care 2	<input type="checkbox"/> Level of Care 0 <input type="checkbox"/> Level of Care 3 <input type="checkbox"/> Level of Care 1M <input type="checkbox"/> Level of Care 4 <input type="checkbox"/> Level of Care 1S <input type="checkbox"/> Level of Care 5 <input type="checkbox"/> Level of Care 2 <input type="checkbox"/> Level of Care 9
<p>Request Approval for Deviation from Recommended Level of Care: If recommended level of care generated from the CMBHS system differs from the provider requested level of care, please provide an explanation in this space. Please attach the enrollee ANSA assessment to this request.</p>	

Child / Adolescent Clients	
Please indicate the recommended level of care generated from the CMBHS system.	Please indicate the provider requested level of care.
<input type="checkbox"/> Level of Care 0 <input type="checkbox"/> Level of Care 4 <input type="checkbox"/> Level of Care 1 <input type="checkbox"/> Level of Care YC <input type="checkbox"/> Level of Care 2 <input type="checkbox"/> Level of Care 9 <input type="checkbox"/> Level of Care 3	<input type="checkbox"/> Level of Care 0 <input type="checkbox"/> Level of Care 4 <input type="checkbox"/> Level of Care 1 <input type="checkbox"/> Level of Care YC <input type="checkbox"/> Level of Care 2 <input type="checkbox"/> Level of Care 5 <input type="checkbox"/> Level of Care 3 <input type="checkbox"/> Level of Care 9
<p>Request Approval for Deviation from Recommended Level of Care: If recommended level of care generated from the CMBHS system differs from the provider requested level of care, please provide an explanation in this space. Please attach the enrollee CANS assessment to this request.</p>	

Name of Person Completing Form	
Phone & Fax Number of Person Completing Form	

Name and Mailing Address of Provider Entity	
Provider Entity National Provider Identifier (NPI)	
Provider Entity Tax ID	
Name of Targeted Case Manager	
Targeted Case Manager Primary Phone Number	