AmeriHealth Caritas Louisiana

Crisis Intervention Follow-Up Request Form

www.amerihealthcaritasla.com

When complete, please fax to **1-855-301-5356**.

All out-of-network provider requests will be reviewed for medical necessity of services.

Crisis intervention follow-up services require **prior** authorization.

Please print clearly — incomplete or illegible forms will delay processing.

Member Information

Member name: _____

Member date of birth: _____ Member ID number: _____

Legal guardian: _____

Member primary diagnosis: _____

Provider Information

Provider name: _____ NPI number: _____

Group/agency name: _____ Phone: _____

Physical address: _____ Fax: _____

The provider is: ☐ In network ☐ Out of network ☐ In credentialing process

Provider credentials: ☐ M.D. ☐ Ph.D. ☐ L.M.H.P. ☐ Bachelor's level ☐ N.P.

☐ Other: _____

Provider contact name: _____

Please complete the **Service Information** section of the form on page 2.

Initial Crisis Intervention Notification Request Form

Service Information

Dates of service: _____

Place of service: ☐ Home ☐ School ☐ Other: _____

When did the initial crisis occur? _____

Explain/give an overview of what the initial crisis involved: _____

_____

All expected participants in the crisis intervention follow-up sessions: _____

_____

Summary of the crisis/symptoms and interventions to be completed: _____

_____

_____

Authorization request: Please note crisis intervention follow up is authorized following an initial crisis intervention service. Crisis intervention follow up can only be authorized for up to 66 hours per episode or until the resolution of the crisis. Episodes cannot exceed 14 days. If a member has another crisis within seven calendar days of a previous episode, it will be considered part of the previous episode and a new episode will not be allowed.

Service code: _____ Dates of service: _____ Units requested: _____

I certify that I have received crisis intervention follow-up services. I understand payment will be from federal, state, and local funds. These are sometimes called public funds. I also understand that if I conceal facts or make false claims, statements, or documents, I may be prosecuted. By signing below, I agree that I (or my child) have received these services.

Member/legal guardian signature: _____ Date: _____

☐ Member and/or legal guardian declined

☐ Member and/or legal guardian unable to sign the encounter form due to: _____

Provider signature: _____ Date: _____

If you have any questions please contact Behavioral Health Utilization Management at **1-855-285-7466**.