DBT SERVICES AUTHORIZATION REQUEST
(Non-contracted providers only)

For Medica members, please fax completed form to 1/855-454-8155
Call 1-800-848-8327 for Medica eligibility and benefit questions.

Member Name:_____ Date of Birth:_____

Medica #_____ Therapist/Facilitator Name: _____

Agency Name: _____ Program address: _____

OUTPATIENT DBT TREATMENT

Contracted Code to use: _____

Will the DBT treatment services provided be billed in**:** ☐ **Per Diem** **or** ☐ **Hourly (15 min)**

PER DIEM: Total # of Days being requested, if providing Per Diem service _____

-OR-

15 MINUTE INCREMENTS: Total # of Treatment Units being requested, if providing treatment in quarter hour increments (*SPP/PMAP/Government plan members only)

Number of Group/Skills Units (15 min/unit; H2019 U1 HQ; HA modifier added for child/adol)

Number of Individual Units (15 min/unit; H2019 U1; HA modifier added for child/adol)

DATES OF SERVICE:

Original admit date:_____ Proposed discharge date: _____

First date of this request:_____ End date of this request: _____

CLINICAL INFORMATION:

DSM5: _____

CURRENT SX & BEHAVIORS/PROGRESS UPDATE:

_____

_____

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Please attach any information or materials that will assist in evaluating the Member's needs