

Family Based Mental Health Services Recommendation Letter

Demographics

Member's Name: _____ MAID#: _____ DOB: _____

Member's Preferred Name: _____

Address: _____

Phone #: _____

Member County:

Cumberland Dauphin Franklin Fulton Lancaster Lebanon Perry

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race: _____ Member's Ethnicity: _____

Member's Sexual Orientation: _____ Member's Gender Identity: _____

Member's Assigned Sex at Birth: _____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Clinical Recommendation

Current Behavioral Health Diagnoses: _____

Determination of eligibility (all criteria must be met)

One adult member agrees to participate in FBMH Services treatment.

The child is at risk for out of home placement; or,
 If initial request returning from residential placement; or
 If initial request stepping down from inpatient stay.

The child has a mental illness or emotional disturbance. Please indicate if known _____.

The child serving systems involved with this child are in agreement with a request for FBMH services.

Recommendation:

I recommend Family Based Mental Health Services for the above-mentioned child and his/her family.

Signature of Prescriber: _____ Date: _____

Printed Name of Prescriber: _____

Address line 1: _____ State: _____

Address line 2: _____ Zip: _____

City: _____ Prescriber's phone number: _____

Please indicate professional title: Licensed Psychiatrist Licensed Psychologist Licensed Physician

MA Provider ID: _____

Provider NPI#: _____

(Please enter the 9-digit MA Provider #)

All aspects of this form need completed or the request will not be accepted as a complete request for medical necessity review by PerformCare.