PerformCARE®

Music Therapy Authorization Request Form

****Out of Network (OON) Providers: A detailed rationale for utilizing an OON Provider including why an INN Provider is unable to meet the member's treatment needs must be included with your request.**

Release of Information for PerformCare: ☐ Yes ☐ No

Member Information

Member Name: ________________________________ MAID: _________________ DOB: _______

Referral Source: ____

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: __________________________

Provider Information

Therapist Name (including credentials): ____

Provider Name for Authorization: ____

Provider Address: ____

Provider Phone #: _______________________ Provider Fax #: _____________________

Provider Contact: ____________________________________

PerformCARE®

Authorization

☐ Initial ☐ Continued Stay

☐ Individual Therapy (G0176)

☐ Group Therapy (G0176 TT)

Start Date Requested: ___________________________

Note: Updated treatment plans, progress notes, objective measures that have been utilized and all other treatment updates must be included for all continued service requests.

Rational for Music Therapy (must include Member's behavioral health needs to be addressed by music therapy)

Current DSM Diagnoses: ____

Danger to Self or Others? ☐ Yes ☐ No

If yes, explain: ____

Current Treatment (other than Music Therapy):

Service	Agency Name

Comments:

Discharge Date: _________________________

Discharge Plan: