



Behavioral Health Criteria Set Request Form
Fax: 813-960-2492

*****Please type or write legibly or request will be returned as unable to process*****

Date of request: _____

Member: _____ Provider name/credential: _____ Provider telephone: _____

Member DOB: _____ Member age: _____ Provider fax: _____

Member ID: _____ Service address: _____ City/State/Zip: _____

Provider ID/NPI: _____ Tax ID: _____

Type of Service	
Please select one:	Please select one:
<input type="checkbox"/> Mental health	<input type="checkbox"/> Member has not received services yet (Pre-service)
<input type="checkbox"/> Substance use	<input type="checkbox"/> Member is currently receiving services (Concurrent)
<input type="checkbox"/> Applied behavior analysis (ABA)	

Level of Care		
<input type="checkbox"/> Inpatient (IP) mental health	<input type="checkbox"/> IP detox	<input type="checkbox"/> Outpatient (OP)
<input type="checkbox"/> Residential treatment (RTC)	<input type="checkbox"/> Partial hospitalization (PHP)	<input type="checkbox"/> Community day treatment (CDT)
<input type="checkbox"/> IP rehab	<input type="checkbox"/> Intensive outpatient (IOP)	<input type="checkbox"/> Personalized recovery oriented services (PROS)
		<input type="checkbox"/> Other:

Reason for Request:

Person to receive criteria set:		
Name:		
Relationship to member receiving services:		
Phone number:		
Address:		
Please provide information for your preferred method of receiving the criteria set:		
Fax:	Email:	Mail: