Member's Full Name: Medicaid #:

SERVICE REGISTRATION FORM

The information on this form must be submitted to the member's plan. **Each requested service must be submitted separately. Multiple services cannot be registered on the same form.**

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian (if applicable):		Clinical Contact Name & Credentials*:	
Parent/Guardian (if applicable) contact information:		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

CLINICAL INFORMATION	
Primary Diagnosis	
Secondary Diagnosis	
Service Type	☐ Mental Health
Requested Start Date	

REQUESTED SERVICE FOR REGISTRATION
☐ Mental Health Case Management (H0023)
☐ Crisis Stabilization (H2019) [Initial Only]
☐ Crisis Intervention (H0036) [Initial Only]
☐ MH Peer Supports (H0024/H0025) [Initial Only]