PerformCARE®

Adjunct Service Prior Authorization Request Form

Adjunct MH OP and other disallowed services require Prior Authorization to ensure that duplication of services does not occur with a currently approved Level of Care for a Member. Refer to PerformCare Provider Notice AD 25- 02 Pre-Payment Claims Edits for Duplicate / Disallowed Services for Levels Of Care considered a duplication of services.

Member Information

Member Name: _____ MAID: _____ DOB: _____

Member Address: _____ Phone #: _____

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 / Staff Name (including credentials): _____

Provider Name for Authorization: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

Provider Contact: _____

Please complete the following:

Signed release for PerformCare? ☐ Yes ☐ No

Offered provider choice? ☐ Yes ☐ No

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Communication with PCP or other relevant health practitioners about treatment? ☐ Yes ☐ No

If no, did Member decline? ☐ Yes ☐ No

Other insurance (name/Policy #): _____

Reason other insurance not used: _____

Authorization Request

Diagnosis codes: _____

Currently PerformCare-approved services: _____

Service requested via the Adjunct request form: _____

Please note that if service requested requires prior authorization, an authorization request for the service must also be submitted in addition to the adjunct request form.

Describe current behaviors/symptoms, clinical rationale and explain the unique member's treatment needs in detail that require 2 concurrent services per disallowed service as described in AD 25-02 in addition to the currently approved services/LOC above:

If requesting MH OP or SU OP level care as an Adjunct, please complete the following section

Code	Description	Start Date	Units (Minutes)	Units Requested
90791	Diagnostic Interview ☐ HO Masters ☐ HP Doctoral			
90832	Individual Psychotherapy 30 min			
90834	Individual Psychotherapy 45 min			
90837	Individual Psychotherapy 60 min			
90847	Family Psychotherapy with Member (15 min units)			
90846	Family Psychotherapy without Member (15 min units)			
90853	Group Psychotherapy (15 min units)			
	Other: _____			