AMHD
ADULT MENTAL HEALTH DIVISION

Utilization Management
PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6989, 453-6981 Fax: 453-6995

Service Authorization Request

Crisis Support Management

All fields are **mandatory.** UM may send back requests that are inaccurate or missing fields. The provider may not add additional fields, categories or otherwise amend this form in any way. Requests for authorization must be submitted to UM within thirty (30) days of the provision of service.

Consumer Information

Name (Last Name, First Name, Middle Initial) :		
Date of Birth:	SSN:	Phone:

Insurance information

If other coverage is available, this authorization is not effective or binding for the Adult Mental Health Division. Consumers with existing CBCM through AMHD or CCS are not eligible for CSM.

Type of insurance:	QI ☐	SLIMB ☐	Non-Pay ☐	CCS ☐	Uninsured ☐	Other ☐

Diagnostic Information

ICD 10 Code:	ICD 10 Code:

A minimum of **one** AMHD eligible ICD-10 code is necessary for authorization.

Provider Information

Agency:		Submitted by:
Phone:	Fax:	Date of Submission:

Attestation *I attest that the service requested is clinically necessary for the above named consumer. I have reviewed and approved the information in the service authorization request.*

QMHP Name: (Please Print)	
License type:	Date Signed:
Signature:	

Authorization Information

Discharge ☐ Date of Discharge: __________

Discharge Criteria:							
Deceased		Unable to locate		Refuses services		Inpatient	
Linked to Family/Friends		Residential Tx		Incarceration		Moved from State/County	
Linked with CCS		Homeless Shelter		Linked to AMHD CBCM		Discharged without linkage	
Other Discharge Criteria (please specify):							
If Residential Tx, Homeless Shelter, AMHD CBCM, or Hospital is selected as the discharge reason state the name of agency the consumer is being discharged to.							