Utilization Management
PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6904, 453-6981 Fax: 453-6995

AMHD
ADULT MENTAL HEALTH DIVISION

Service Authorization Request

CBCM Increased units

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:	CR ☐	ROC ☐	MHC ☐	JD ☐	**Legal Status**

Insurance information If other coverage is available, this authorization is not effective or binding for the Adult Mental Health Division.

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

Case Manager Information

Name of Agency:	Name of Case Manager:
Case Manager's Phone:	Case Manager's Fax:
Submitted by:	Date of Submission:

Authorization Information **A current, signed treatment plan must accompany this request, UM may requests progress notes to assist in making a determination of clinical necessity.**

→ **Crisis Units**	Authorization Number:						
Service date(s) for Crisis Units:					Number of additional units:		
→ **Duration Units**	Authorization Number:						
Jan, Feb, March	☐	April, May, June	☐	July, Aug, Sept	☐	Oct, Nov, Dec	☐ ← **Select Quarter**
← **Units for Month 1**		← **Units for Month 2**		← **Units for Month 3**			

Please describe the current circumstances or recent (within the last three months) clinical history that justify the provision additional units, submit additional information as needed.

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:	