

Rehabilitative Behavioral Health Services (RBHS) Referral Form

This form shall be completed only by state agencies and submitted to private RBHS providers in accordance with HIPAA regulations as it contains Protected Health Information (PHI) of Medicaid beneficiaries.

Referring State Agency	<input type="checkbox"/> Department of Social Services	<input type="checkbox"/> Department of Disabilities and Special Needs
	Region:	Region:
	<input type="checkbox"/> Department of Mental Health	<input type="checkbox"/> Department of Juvenile Justice
	CMHC:	Region:
	<input type="checkbox"/> Continuum of Care	<input type="checkbox"/> Department of Education
	Region:	District:
	<input type="checkbox"/> Department of Alcohol and Other Drug Abuse Services	
	Commission:	

Provider (Referred to)				NPI	
Address					
City		State		Zip	
Phone Number		Fax Number			

Beneficiary Name					
Legally Responsible Person(s)					
Address					
City		State		Zip	
Date of Birth		Gender	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Social Security Number (last 4 digits)		Medicaid Number			

Medical Necessity	
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Diagnosis – Code / Description	/
Clinical Rationale for Rehabilitative Behavioral Health Services Recommendations	

I recommend that the above-named Medicaid beneficiary receive Rehabilitative Behavioral Health Services. This beneficiary meets the Medical Necessity criteria for services as evidenced by a mental health and/or substance use disorder from the current edition of the DSM or the ICD.

Name of LPHA/Qualified Clinical Professional:

Credentials:

Signature of LPHA/Qualified Clinical Professional:

Date:

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
SCREENING AND ASSESSMENT SERVICES							
<input type="checkbox"/>	Behavioral Health Screening	H0002	15 minutes				
<input type="checkbox"/>	Psychiatric Diagnostic Assessment without Medical Services - Initial	90791	Encounter				
<input type="checkbox"/>	Psychiatric Diagnostic Assessment with Medical Services – Initial	90792	Encounter				
<input type="checkbox"/>	Mental Health Comprehensive Diagnostic Assessment – Follow-up	H0031	Encounter				
<input type="checkbox"/>	Psychological Testing / Evaluation	96101	60 minutes				
<input type="checkbox"/>	Comprehensive Evaluation – Initial	H2000	Encounter (average of 3 hours)				
<input type="checkbox"/>	Comprehensive Evaluation – Follow up	H0031	Encounter				
SERVICE PLAN DEVELOPMENT							
<input type="checkbox"/>	Mental Health Service Plan Development (Non-physician)	H0032	15 minutes				
<input type="checkbox"/>	Service Plan Development (Team Conference w/ Client/Family)	99366	Encounter (minimum 30 minutes)				
<input type="checkbox"/>	Service Plan Development (Team Conference w/o Client/Family)	99367	Encounter (minimum 30 minutes)				
CORE TREATMENT – PSYCHOTHERAPY AND COUNSELING SERVICES							
<input type="checkbox"/>	Individual Psychotherapy	90832	20-30 minutes				
<input type="checkbox"/>	Individual Psychotherapy	90834	45 minutes				

Recommendations for Rehabilitative Behavioral Health Services							
	Service Description	Procedure Code	Unit	Total Units Authorized	Start Date	End Date	Specific Frequency (# of units per day, # of days per week)
<input type="checkbox"/>	Individual Psychotherapy	90837	60+ minutes				
<input type="checkbox"/>	Group Psychotherapy	90853	60+ minutes				
<input type="checkbox"/>	Family Psychotherapy w/o Client	90846	60+ minutes				
<input type="checkbox"/>	Family Psychotherapy w/ Client	90847	60+ minutes				
<input type="checkbox"/>	Multiple Family Group Psychotherapy	90849	60+ minutes				
<input type="checkbox"/>	Crisis Management	H2011	15 minutes				
<input type="checkbox"/>	Medication Management	H0034	15 minutes				
COMMUNITY SUPPORT SERVICES							
<input type="checkbox"/>	Psychosocial Rehabilitation Service (PRS)	H2017	15 minutes				
<input type="checkbox"/>	Behavior Modification (B-Mod)	H2014	15 minutes				
<input type="checkbox"/>	Family Support (FS)	S9482	15 minutes				

Note: Prior authorized periods of time for Community Support Services are as follows:

- Beneficiaries ages 0 to 21: 90 days
- Beneficiaries age 22 and older: 180 days

State Agency Representative Authorization (optional, per internal state agency processes)

Name:

Phone:

Title:

Signature:

Date: