

Maine Behavioral Health ASO, APS CareConnection® Authorization Request Form.

Please submit this information via APS CareConnection®

Outpatient/Med Management Services Only- Continued Stay Request

Items marked with an asterisk (*) are required

*Member MeCare ID:		*Date of Birth:		*SSN:	
*Member First Name:			*Last Name:		
*Provider Org:		*Adult / Child / Psychological Services (circle one)			
*Service Code:		*Billing Provider MaineCare ID:			
*Start Date:		*End Date:		*Units:	*Frequency:
*Is member prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> NO					
Medications:					
*Primary ICD-9 Dx:		*Axis I ICD-9 Dx:		*Axis II ICD-9 Dx:	
*Axis III Dx:					
*Axis IV: <i>Write none, mild, moderate or severe</i>			Custody/Placement Issues _____		
Problems in Family Relations _____			Financial Difficulties _____		
Problems in Friendship/Social Relations _____			Problems in Living Situation _____		
Legal Issues _____			Physical Health _____		
School Problems _____			Problems With Access to HealthCare _____		
Work Problems _____			Other Psychosocial & Environmental Problems _____		
*Axis V score : _____ Since last authorization GAF has: <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Not changed <input type="checkbox"/> Unknown					
*Symptom:	Severity: None, mild, moderate, severe	History: Within-- 7 days, 8-90 days, 3-12 months, 1-10 Years, 10+ years	*Symptom:	Severity: None, mild, moderate, severe	History: Within-- 7 days, 8-90 days, 3-12 months, 1-10 Years, 10+ years
Assaultive:			Use of Weapons:		
Aggressive:			Self Care Deficit:		
Fire Setting:			Self-Injurious Behavior:		
Harm to Animals:			Sexually Inappropriate Bx:		
Homicidal Attempt:			Suicide Attempt:		
Homicidal Ideation:			Suicidal Ideation:		
*Select the tool or tools used to screen for co-occurring mental health and substance use disorders. Next to each selected tool, indicate if there were one or more YES responses. If the AC-OK is used, answer for all 3 domains. If the MHSF III is used, CRAFFT or UNCOPE must also be used.					
This Tool Used: AC-OK MH Issues Domain <input type="checkbox"/> Yes <input type="checkbox"/> No			This Tool Used: UNCOPE <input type="checkbox"/> Yes <input type="checkbox"/> No		
This Tool Used: AC-OK Trauma Issues Domain <input type="checkbox"/> Yes <input type="checkbox"/> No			This Tool Used: CRAFFT <input type="checkbox"/> Yes <input type="checkbox"/> No		
This Tool Used: AC-OK Sub Abuse Issues Domain <input type="checkbox"/> Yes <input type="checkbox"/> No			This Tool Used: MHSF III <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Date of assessment for co-occurring disorders:					
Please provide additional information to support request for services, as needed.					
*Treatment Progress: (circle one) Other/ Deteriorated/ None/ Minimum/ Moderate /Significant					

*Provider Signature: _____ *Provider Phone: _____

*Provider Name: _____ *Date: _____