



MEDICATION MANAGEMENT REGISTRATION FORM

Prescribers need to complete this form when requesting Medication Management only.

If other outpatient services are being requested, please complete the Outpatient Registration Form (ORF1) or the Outpatient Review Form (ORF 2) as appropriate.
PLEASE TYPE OR PRINT LEGIBLY. Check/circle response where applicable.

Requested Start Date for this Authorization ____/____/____

Type of Service Requested: Mental Health Substance Abuse

Patient Name _____

Date of Birth: _____ Age: _____ M F

Address (City/State only): _____ Tel. #: _____

Patient's Insurance ID#: _____

Patient's Employer/Benefit Plan: _____

Provider Name: _____ License: _____

Provider Program/Clinic (if applicable): _____

VO Provider # (if known): _____

Service Address: _____ Tel. #: _____

City/State/Zip: _____

Are you independently licensed to provide services in the State where you are treating this patient? Yes No

ID #: _____ *Check Which:* SSN Tax ID NPI

Diagnosis:

Axis I: 1. _____ 2. _____

Axis II: 1. _____ 2. _____

Axis III: 1. _____ 2. _____

Axis IV: 1. _____ 2. _____

Axis V: Current GAF = _____ Highest GAF in the past year = _____

REQUESTED SERVICES: *Please indicate type(s) of service provided and frequency.*

Medication Management 90862 Wkly Mnthly Qtrly Other _____

Medication Management 90805 Wkly Mnthly Qtrly Other _____

Other _____ Wkly Mnthly Qtrly Other _____

Other _____ Wkly Mnthly Qtrly Other _____

Treating Provider's Signature: _____

Date: _____