

## **Children's CFTSS Services**

## Notification of Service/Request for Concurrent Authorization

Please complete the following and attach this cover sheet to the Treatment Plan. Please include all relevant progress notes.

Initial Service	Concurrent Authorization Reques
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## **Member Information:**

Member Name:		DOB:
Member ID#:	PCP: _	
Guardian:	_Contact info: _	
Health Home Care Manager:		Phone #:
Diagnoses (ICD-10 codes and descriptions):		
Provider Information:		
Provider/ Agency Name:		

Contact Name (if questions on request or treatment plan): \_\_\_\_\_

Site Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Service	HCPCS code	Time per day (min/hour)	Days per week	Individual or Group	Onsite or Offsite
Community Psychiatric Support and Treatment (CPST)					
Psychosocial Rehabilitation (PSR)					
Other Licensed Practitioner (OLP)					
Family Peer Support Services (FPSS)					
Youth Peer Support Services (YPSS)					

Requesting:			
Time frame: Start date:	End date:		
Date of Initial Assessment:			
Member Original Treatment Plan Date:			
Date of Most Recent Treatment Plan Update:			