State of Maryland

PROVIDER REQUEST TO CSA\LBHA FOR URGENT CARE FOR UNINSURED **Form Dated 12/01/2017**

(Form to be sent by Provider to the CSA\LBHA for Approval)

CONSUMER NAME:	**START DATE DESIRED:**	**DOB:**	**SSN:**
Address:			

INCOME:	**INSURANCE**
Annual Income: $ _____	MA: _____ (Application Date)
Monthly Income: $ _____	MEDICARE: ☐ Yes ☐ No
Income Source: _____	
# of Dependents: _____	

Clinical Indications for (Continued) Outpatient Services:
Please check YES or NO

Hx Suicide Attempts:	☐ **YES** ☐ **NO**		Dates/Details:
Hx of Psychiatric Hospitalization:	☐ **YES** ☐ **NO**		When/Where:
Hx of Clinical Deterioration:	☐ **YES** ☐ **NO**		Explain:
Hx of Arrests:	☐ **YES** ☐ **NO**		When/Where:
Psych. Dx:	☐ **YES** ☐ **NO**		**DSM-5\ICD-10 code: (if applicable)**

Explain Why Request is Urgent, What Else Has Been Tried; What Services Were Sought but Denied? ***Case Mgmt. – state specific reason(s)***	
	CSA\LBHA and BHA Area Only ***(This shaded area is only for CSA\LBHA and BHA use only)***
CSA\LBHA USE ONLY **Request for Case Mgmt. Exception**	☐ Discharge from hospital ☐ Release from incarceration ☐ Diversion from hospital or jail ☐ At risk of homelessness/homeless ☐ NCR ☐ Other
CSA\LBHA Approves C\M Exception ☐ Yes ☐ No	**CSA\LBHA Signature:** **Date:**
***FOR BHA USE ONLY*:** **CASE MGMT. EXCEPTION REQUEST**	☐ **Marian Bland, BHA** **Email: marian.bland@maryland.gov** **Fax: (410) 402 - 8301** ☐ **Steve Reeder, BHA** **Email: steven.reeder@maryland.gov** **(410) 402 - 8309** ☐ **Russell Springham, BHA** **Email: russell.springham@maryland.gov** **(410) 402 - 8301**
FOR BHA USE ONLY: **APPROVAL/DENIAL OF CASE MGMT. EXCEPTION REQUEST**	☐ **APPROVED** ☐ **NOT APPROVED** **Reason for Denial:** ☐ Ineligible Diagnosis ☐ Exception Reason Not High Priority ☐ BHA funds unavailable at this time ☐ Refer consumer to other community service ☐ Other: _____ **BHA Signature:** _____ **Date:** _____ / _____ / _____

CSA\LBHA Approves Reimbursement:	☐ Yes	☐ No	CSA\LBHA Priority:	☐ Urgent	☐ High

CSA\LBHA**:** Phone number:	_____ _____	***Fax Number:** Email:	_____ _____
Signature:		Date: _____ / _____ / _____	

**** CSAs\LBHAs: Please put fax number on this form prior to faxing the form over to BHA to request Uninsured C/M Services approval ****