Medical Necessity Criteria Request Form

If you would like to request a copy of the Medical Necessity Manual for Behavioral Health, you must request the specific level of care criteria that you would like to review. You may request a copy of the criteria by phone, mail or fax.

- To request a copy by **phone**, please call 305-514-5300 or 1-855-541-5300, option 2, option 1
- To request a copy by **mail,** please complete this form and mail your request to the following address:

  Carisk Behavioral Health
  Attn: Clinical Operations
  10685 N. Kendall Drive
  Miami, FL 33176

- To request a copy by **fax**, please fax this completed form to: 305-514-5321

Date of Request: _____/_____/_____

Please select one: ☐ I would like to receive the criteria by mail ☐ I would like to receive the criteria by fax

Please select one: ☐ I am a participating Practitioner

Requestor's Name: _____

Address (if requesting a mail copy): _____

_____

Telephone Number: _____ **Fax Number:** _____

Level of Care
Please select the specific criteria relevant to your practice or care for which you would like to receive information:

☐ Outpatient Mental Health
☐ Outpatient Substance Abuse
☐ Mental Health Intensive Outpatient
☐ Intensive Outpatient Substance Abuse
☐ Psychological Testing
☐ Acute Care Mental Health - Adult
☐ Acute Care Substance Abuse - Adult
☐ Acute Care Mental Health - Child
☐ Acute Care Substance Abuse - Child
☐ Partial Hospitalization Program
☐ Other _____

Internal Use Only:

Date Request Completed: _____/_____/_____ ***By Staff Member (Name):*** _____

Criteria Section sent via: ☐ Mail ☐ Fax ***Staff Member Signed Initials:*** _____