	Health and Human Services Agency – Utilization Management **Organizational Provider Face Sheet** ***Confidential***

This form is to be used only for services not requiring a prior authorization.

Client Name: ________________________________ DOB ________________ **Chart Number:** _____________

Select the documents being submitted:

___ New Patient Registration Form ___ Initial ___ Update

___ Program Diagnosis and Discharge Form ___ Initial ___ Update ___ Discharge

___ Comprehensive Assessment ___ Initial ___ Update

___ CANS (when applicable) ___ Initial ___ Update ___ Discharge

___ Treatment Plan (STRTP, CTF) (when no services requiring a prior auth are being requested.) ___ Initial ___ Update or Annual

- **The services below do not require an authorization for service or payment.** Mental Health Services, including initial assessment, Crisis Intervention, Medication Support Services, Targeted Case Management, Intensive Care Coordination, and Peer Support Services
- **Care Plans are required for the following services. Each care plan is documented in a progress note and does NOT need to be submitted to the County.**
  - Targeted Case Management, Intensive Care Coordination, and Peer Support Services.
- **Services that need prior authorization should be requested using the Treatment Authorization Request form.** (Services needing prior authorization include: Intensive Home-Based Services, Therapeutic Behavioral Services, Day Treatment Intensive, Day Rehabilitation, and Therapeutic Foster Care.)

To be completed by the Shasta County Utilization Management

Date Received: _____________ Date Reviewed: ______________ Reviewed by: ____________________________

County Code ___________ Aid Code ____________ Verified by _________________________ Date: ____________

Comments: