DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	September 1, 2014	Initial version of Uniform Managed Care Manual Chapter 15.2, "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Form" Chapter 15.1 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, 529-12-0002, and 529-13-0042.
Revision	2.1	September 1, 2014	Form is reformatted for clarity.

[1] Status is represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.
[2] Revisions are numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

Targeted Case Management and Rehabilitative Services Request Form

Date of Completion of CANS / ANSA	
Dates of Service Requested	
Member Name	
Medicaid Identification Number	
Primary Diagnosis (if more than one primary diagnosis, enter up to 5 codes separated by commas)	
Purpose of Form (specify if initial assessment LOC or re-assessment LOC)	

Adult Clients

Please indicate the **recommended level of care** generated from the CMBHS system.		Please indicate the **provider requested** level of care.	
☐ Level of Care 0	☐ Level of Care 3	☐ Level of Care 0	☐ Level of Care 3
☐ Level of Care 1M	☐ Level of Care 4	☐ Level of Care 1M	☐ Level of Care 4
☐ Level of Care 1S	☐ Level of Care 9	☐ Level of Care 1S	☐ Level of Care 5
☐ Level of Care 2		☐ Level of Care 2	☐ Level of Care 9

Request Approval for Deviation from Recommended Level of Care: If recommended level of care generated from the CMBHS system differs from the provider requested level of care, please provide an explanation in this space. Please attach the enrollee ANSA assessment to this request.

Child / Adolescent Clients

Please indicate the **recommended level of care** generated from the CMBHS system.		Please indicate the **provider requested** level of care.	
☐ Level of Care 0	☐ Level of Care 4	☐ Level of Care 0	☐ Level of Care 4
☐ Level of Care 1	☐ Level of Care YC	☐ Level of Care 1	☐ Level of Care YC
☐ Level of Care 2	☐ Level of Care 9	☐ Level of Care 2	☐ Level of Care 5
☐ Level of Care 3		☐ Level of Care 3	☐ Level of Care 9

Request Approval for Deviation from Recommended Level of Care: If recommended level of care generated from the CMBHS system differs from the provider requested level of care, please provide an explanation in this space. Please attach the enrollee CANS assessment to this request.

Name of Person Completing Form	
Phone & Fax Number of Person Completing Form	
Name and Mailing Address of Provider Entity	
Provider Entity National Provider Identifier (NPI)	
Provider Entity Tax ID	
Name of Targeted Case Manager	
Targeted Case Manager Primary Phone Number	