



FAXED MEMBER RELEASE OF INFORMATION, REQUEST FOR AUTHORIZATION FOR SERVICES & TRANSFER OF KCPC FILE TO A NEW PROVIDER

If all information listed below is not completed in full and submitted, this will be considered an "Incomplete Request" and ValueOptions will be unable to process the request. The authorization for services will be effective the date this completed fax request is received at ValueOptions.

PLEASE FILL OUT COMPLETELY and FAX TO 877-591-3940

Facility Information

Full Name of Your Facility _____

Complete Address _____

Contact Person _____

Phone # & Ext. # of Contact Person (____) ____-_____

Member Information

Member's Full Name _____

Member DOB ____/____/____ Member SSN# (if available) ____-____-____

Member Unique I.D. (if available) _____

Level of Care Member is Entering at Your Facility:

- Level I, Individual Only Level I, Group Only Level I, Individual & Group
- Level II, Intensive Outpatient Level III.2-D, Social Detox Level III.1 Reintegration
- Level III.3 or III.5, Intermediate Medicaid CM Person Centered CM
- Support Services Peer Support Overnight Boarding: # of Children _____

Clinical justification for the requested Level of Care:

Date Member started treatment at this Level of Care at your Facility ____/____/____

If the date the Member started treatment is greater than 60 days from the date of the KCPC (due to incarceration) or greater than 30 days from release of incarceration: Date of release ____/____/____

If this is a Transfer from a previous provider, did you speak with that provider to confirm that a pre-approval for the level of care was secured (if other than Social Detox) and that they have completed and forwarded the KCPC to ValueOptions so the file can be transferred to you? Yes No