

 **VALUEOPTIONS MEDICATION MANAGEMENT REGISTRATION FORM**

Prescribers need to complete this form when requesting *Medication Management only*.

If other outpatient services are being requested, please complete the Outpatient Registration Form (ORF1) or the Outpatient Review Form (ORF 2) as appropriate. PLEASE TYPE OR PRINT LEGIBLY. Check/circle response where applicable.

Member Demographics:

Member's Name: _____
Date of Birth: _____ Member's Age: _____ Gender: M F
Member's Address (City/State only): _____
Member's ID #: _____
Insured's Employer/Benefit Plan: _____

Provider Demographics:

Provider Name: _____
Provider Program/Clinic (if applicable): _____
VO Provider # (if known): _____
Service Address: _____
City/State/Zip: _____
Provider Telephone#: _____
Are you independently licensed? Yes No
Licensure level (type of license): _____
State which issued this license: _____
Provider SSN or Tax ID #: _____

Diagnosis:

Axis I: 1. _____ 2. _____
Axis II: 1. _____ 2. _____
Axis III: 1. _____ 2. _____
Axis IV: _____
Axis V: Current GAF = _____ Highest GAF in the past year = _____

Requested Services:

Requested Start Date for this registration: _____
Please circle type of service requested: Mental Health Substance Abuse
Please indicate type(s) of service provided and frequency.
 Medication Management 90862 Wkly Mnthly Qtrly Other _____
 Medication Management 90805 Wkly Mnthly Qtrly Other _____
 Other _____ Wkly Mnthly Qtrly Other _____
 Other _____ Wkly Mnthly Qtrly Other _____

Treating Provider's Signature: _____
Date: _____