

EXPEDITED REVIEW REQUEST
Mental Health Plan Payment Authorization
For Therapeutic Behavioral Services
Mental Health Plan Name: _____

Initial Authorization Request _____ Reauthorization Request _____

Provider Information	Beneficiary Information
Provider Name	Beneficiary Name
Provider Address	Beneficiary Medi-Cal Number
Provider Number _____ Phone Number _____	DOB _____

Provider Certification:

I certify under penalty of perjury that an expedited review of the accompanying MHP payment authorization request is necessary because the standard 14 day authorization timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function.

Signature of Provider _____ Date _____

Examples of Reasons for an Expedited Request

Without TBS, the beneficiary is likely to be placed at a higher level of care or to require acute psychiatric hospitalization within the next 14 days.

The beneficiary is ready to transition to a lower level of residential placement within the next 14 days but cannot do so without TBS.

The request is for the continuation of previous TBS authorization which will end in 14 days or less, resulting in a gap in services, and the request is being made before the end of the previously authorized service period.