illinicare health

SUBMIT TO
Utilization Management Department
PHONE 866-329-4701 | FAX 844-528-3453

MOBILE CRISIS NOTIFICATION FORM

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID #_____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary_____

Tertiary _____

Additional _____

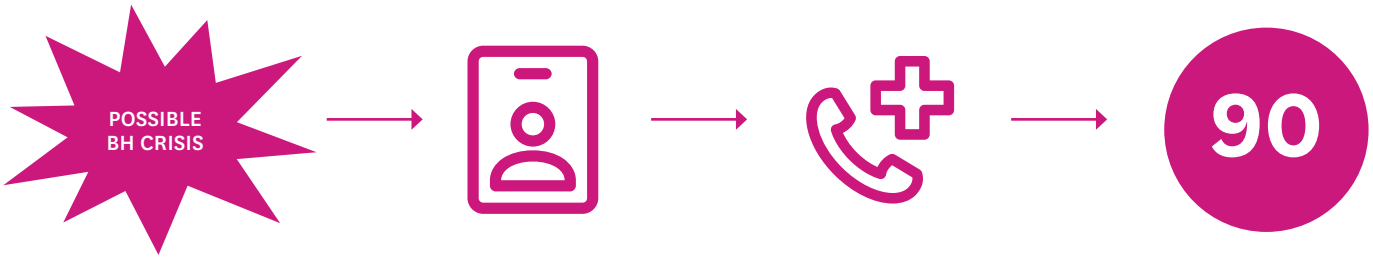
Additional _____

Has contact occurred with family? ☐ Yes ☐ No

Time of call by provider/agency_____

Time of assessment by provider/agency_____

IP Appropriate Hospital ☐ Yes ☐ No



Member identified and CARES is called

If Mobile Crisis appropriate, CARES dispatch to MCR team

MCR Responder arrives in 90 minute window

IM-CAT and Crisis Safety Plan completed

Member is placed in a higher level of care

Member is stabilized in the community

Provider can bill crisis intervention, crisis stabilization, and case management* for **up to 30 days** post-crisis event without prior authorization

*(*Case management requires prior authorization after 200 units)*

Clinician Signature Date

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PLEASE ATTACH IM – CAT and crisis stabilization plan