PerformCARE®

MUSIC THERAPY REQUEST FORM

Submit To: PerformCare
Right Fax: 1-888-987-5828

PRIOR AUTHORIZATION IS REQUIRED
Please print clearly – incomplete or illegible forms will delay processing.

Member Information

Patient Name: _____

Date of Birth: _____

Patient ID#: _____

Referral Source: _____

Release of Information for PerformCare: ☐ Yes ☐ No

Provider Information

Name of Therapist: _____

Professional Credentials: _____

Provider Name: _____

Physical Address: _____

Phone: _____ Fax: _____

Contact Person: _____

Setting requested: Check one for each service:

☐ Individual Therapy (G0176) ☐ Initial ☐ Continued Service

☐ Group Therapy (G0176TT) ☐ Initial ☐ Continued Service

Start date requested: _____

Note: ***Updated treatment plans, progress notes, objective measures that have been utilized and all other treatment updates must be included for all continued service requests*.**

Rationale for Music Therapy (must include the Behavioral Health needs that will be addressed via Music Therapy):

DSM Diagnosis

Diagnosis: _____

Specifier: _____

Danger to self or others? ☐ Yes ☐ No
If Yes, please explain:

List current treatment (other than Music Therapy):

_____

Discharge date and plan:

Comments: _____

PerformCare use only :

D:
AU:
AP:

Provider use only: ☐ Please check here if this is being submitted in response to a PerformCare fax notice.