THE UNITED STATES FIRE DEPARTMENT RESERVE CORPS

FLORIDA MENTAL HEALTH SERVICES COMMAND

ADULT NEW PATIENT / CLIENT AND REFERRAL FORM

NEW PATIENT / CLIENT INFORMATION						
INSTRUCTIONS: IF THE PATIENT/CLIENT IS A MINOR COMPLETE ALL APPLICABLE AREAS AND PROVIDE THE REPRESENTATIVE'S INFORMATION IN THE NEXT SECTION						
Tiles:	First Name:	Middle Name:	Last Name:		Suffix:	
Preferred Name:			Number In Household:			
Date of Birth:	Social Security Number:	Gender: Blank	Race: Blank		Ethnicity: Blank	
Address:	Apartment / Unit:	County:	City:	State:	Zip Code:	
Cell Phone Number:	E-Mail:	Home Phone Number:	Marital Status:			
Employer:	Occupation:	Work Phone Number:				
Employer Address:						

NEW PATIENT / CLIENT REPRESENTATIVE						
INSTRUCTIONS: COMPLETE ALL APPLICABLE AREAS						
Tiles:	First Name:	Middle Name:	Last Name:		Suffix:	
Home Phone Number:			Cell Phone Number:			
Work Phone Number:			E-Mail:			
Address:	Apartment / Unit:	County:	City:	State:	Zip Code:	
Date of Birth:	Gender: Blank	Race: Blank	Ethnicity: Blank			
Marital Status:	Employment Status:	Relationship:				

PRIMARY EMERGENCY CONTACT				
INSTRUCTION: IF DIFFERENT THAN ABOVE.				
Tiles:	First Name:	Middle Name:	Last Name:	Suffix:
Work Phone Number:			Cell Phone Number:	
Relationship to Minor:			E-Mail:	

SECONDARY EMERGENCY CONTACT				
INSTRUCTION: IF DIFFERENT THAN ABOVE.				
Tiles:	First Name:	Middle Name:	Last Name:	Suffix:
Work Phone Number:			Cell Phone Number:	
Relationship to Minor:			E-Mail:	

GOVERNMENT AGENCY/DEPARTMENT REFERRAL SECTION

GOVERNMENT AGENCY/DEPARTMENT/ NAME:	**NATIONAL PROVIDED NUMBER:** (If Applicable)	**TAX ID NUMBER:** (If Applicable)

POINT OF CONTACT (POC) INFORMATION:

Title /Rank:	Badge No:	First Name:	Middle Name:	Last Name:	Suffix:

Work Phone Number:	Cell Phone Number:	E-Mail:

Address:	Suite / Unit:	County:	City:	State:	Zip Code:

REFERRAL SECTION REFER BY

☐ **PHYSICIAN /** ☐ **MENTAL HEALTH AND BEHAVIORAL CLINICIAN /** ☐ **CERTIFIED BEHAVIORAL HEALTH CASE MANAGER**

FACILITY INFORMATION: (If Applicable)

Name:	National Provider Number (NPI):	Tax ID Number:

REFER BY:

Title:	First Name:	Middle Name:	Last Name:	Suffix:

NPI:	Florida State License Number:	Expiration Date:	Florida Certification Board Number:	Expiration Date:

Cell Phone Number:	Secondary Phone Number:	Fax Number:	E-Mail:

Address:	Suite / Unit:	County:	City:	State:	Zip Code:

REQUEST FOR SERVICES STATEMENT

INSTRUCTIONS: IN A FEW SENTENCES DESCRIBE YOUR MAIN CONCERNS AND ISSUES THAT HAVE BROUGHT YOU TO SEEK COMMUNITY BEHAVIORAL HEALTH AND TARGETED CASE MANAGEMENT SERVICES FROM THE UNITED STATE FIRE DEPARTMENT RESERVE CORPS: MENTAL HEALTH SERVICES COMMAND (USFDRC: MHSC).

REQUEST FOR SERVICES

INSTRUCTIONS: PLEASE CHECK THE CHECK BOX FOR ONE OR BOTH SERVICES. IF NEEDED, ATTACH SUPPORTING DOCUMENTATION (MEDICAL RECORDS, PROGRESS NOTES, LAB REPORTS, RADIOLOGY STUDIES, ETC. ARE YOU ATTACHING ADDITIONAL DOCUMENTS TO THIS FORM? ☐ YES ☐ NO
USE THE LAST PAGE TO DESCRIBE ALL ADDITIONAL DOCUMENTS ATTACHED TO THIS FORM.

☐ **Florida Medicaid Community Behavioral Health Agency Services:** The services provide mental health and substance use services to reduce the recipient's mental health or substance use disorder and restore to the best possible functional level.	☐ **Florida Medicaid Mental Health Targeted Case Management Agency Services:** The services provide case management to adults with serious mental illness and children with serious emotional disturbance to assist them in gaining access to needed medical, social, educational, and other services.
Intercurrent Disease Diagnosis: Diagnosis ICD-10 Codes: (FIND-A-CODE LINK)	Intercurrent Disease Diagnosis: Diagnosis ICD-10 Codes: (FIND-A-CODE LINK)
Diagnosis Description:	Diagnosis Description:
Psychiatric Disease Diagnosis: Diagnosis ICD-10 Codes: (FIND-A-CODE LINK)	Psychiatric Disease Diagnosis: Diagnosis ICD-10 Codes: (FIND-A-CODE LINK)
Diagnosis Description:	Diagnosis Description:

CPT/HCPC Codes:	Number of Services:	Frequency of Services:	CPT/HCPC Codes:	Number of Services:	Frequency of Services:

Description of Codes:	Description of Codes:
Diagnosis Date:	Diagnosis Date:
Current treatment Status?	Current treatment Status?

Prominently note medication allergies and adverse reactions in the record; if the patient /client has no known allergies or adverse history reactions, note it in the record:

PRE-AUTHORIZATION

FLORIDA MEDICAID COMMUNITY BEHAVIORAL HEALTH AGENCY SERVICES		**FLORIDA MEDICAID MENTAL HEALTH TARGETED CASE MANAGEMENT AGENCY SERVICES**	
Approved Pre-Authorization Number:	Date:	Approved Pre-Authorization Number:	Date:
PRE-AUTHORIZATION DIFFERENTIA FROM REQUEST		**PRE-AUTHORIZATION DIFFERENTIA FROM REQUEST**	
Number of Services:	Frequency of Services:	Number of Services:	Frequency of Services:
USFDRC Representative Name Requesting Pre-Authorization:		USFDRC Representative Name Requesting Pre-Authorization:	
Primary Phone Number:	E-Mail:	Primary Phone Number:	E-Mail:

USFDRC: MHSC / CBHCM REPRESENTATIVE ASSIGNED TO THE PATIENT / CLIENT

USFDRC: MHSC REPRESENTATIVE ASSIGNED:

Tile/Rank:	First Name:	Middle Name:	Last Name:	Suffix:

NPI:	Florida State License Number:	Expiration Date:	Florida Certification Board Number:	Expiration Date:

Cell Phone Number:	Secondary Phone Number:	Fax Number:	E-Mail:

Address:	Suite / Unit:	County:	City:	State:	Zip Code:

USFDRC: CBHCM SUPERVISOR ASSIGNED:

Tile/Rank:	First Name:	Middle Name:	Last Name:	Suffix:

NPI:	Florida State License Number:	Expiration Date:	Florida Certification Board Number:	Expiration Date:

Cell Phone Number:	Secondary Phone Number:	Fax Number:	E-Mail:

Address:	Suite / Unit:	County:	City:	State:	Zip Code:

USFDRC: CBHCM ASSIGNED:

Tile/Rank:	First Name:	Middle Name:	Last Name:	Suffix:

NPI:	Florida State License Number:	Expiration Date:	Florida Certification Board Number:	Expiration Date:

Cell Phone Number:	Secondary Phone Number:	Fax Number:	E-Mail:

Address:	Suite / Unit:	County:	City:	State:	Zip Code:

STATE-ISSUED IDENTIFICATION CARD

INSTRUCTIONS: PLEASE UPLOAD THE IMAGE OF YOUR PHOTO STATE IDENTIFICATION CARD (ID)

FRONT	BACK

PRIMARY INSURANCE INFORMATION

DOES THE PATIENT / CLIENT HAVE HEALTH INSURANCE? ☐ Yes ☐ No

Insurance Company:		Insurance Card Holder's Name: (If Different than the patient / Client)	
Subscriber ID#:	Group #:	Policy Holder Date of Birth:	Social Security Number:
Co-Pay:	Deductible:	Provider Customer Phone Number:	

PRIMARY INSURANCE CARD

INSTRUCTIONS: PLEASE UPLOAD THE IMAGE OF THE PATIENT / CLIENT INSURANCE CARD (FRONT/BACK). PLEASE CLICK BELOW ON THE CENTER OF THE GRAY AREA, "CHOOSE FILE" TO SELECT AN IMAGE FILE. AFTER SELECTING THE FILE, CLICK THE UPLOAD BUTTON TO UPLOAD THEM. CLICK THE X TO DELETE A FILE.

FRONT	BACK

SECONDARY INSURANCE INFORMATION

DOES THE PATIENT / CLIENT HAVE HEALTH INSURANCE? ☐ Yes ☐ No

Insurance Company:		Insurance Card Holder's Name: (If Different than the patient / Client)	
Subscriber ID#:	Group #:	Policy Holder Date of Birth:	Social Security Number:
Co-Pay:	Deductible:	Provider Customer Phone Number:	

SECONDARY INSURANCE CARD

INSTRUCTIONS: PLEASE UPLOAD THE IMAGE OF THE PATIENT / CLIENT INSURANCE CARD (FRONT/BACK). PLEASE CLICK BELOW ON THE CENTER OF THE GRAY AREA, "CHOOSE FILE" TO SELECT AN IMAGE FILE. AFTER SELECTING THE FILE, CLICK THE UPLOAD BUTTON TO UPLOAD THEM. CLICK THE X TO DELETE A FILE.

FRONT	BACK

INSURANCE BENEFITS STATEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the United States Fire Department Reserve Corps, (USFDRC) Inc. I understand that I am financially responsible for any balance. I also authorize USFDRC and/or the insurance company mentioned above to release any information required to process my claims.

Patient / Client / Guardian Signature:		Witness Signature:	
Name:	Date:	Name:	Date:
Cell Phone Number:	E-Mail:	Cell Phone Number:	E-Mail:

ATTACHMENTS
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FILING INSTRUCTIONS
INSTRUCTIONS: EMAIL THIS FORM, AND ALL ATTACHMENTS TO OIT MARGARETHA A. DEJESUS AT MDEJESUS@USFDRC.ORG. PLEASE FEEL FREE TO CONTACT OIT DEJESUS AT 1-321-332-7100, EXT. 563, IF YOU REQUIRE ANY FURTHER ASSISTANCE AND INFORMATION.

FLORIDA MEDICAID PROCEDURE CPT/HCPS CODES AND FEE SCHEDULE INSTRUCTIONS	
CURRENT PROCEDURAL TERMINOLOGY (CPT)/HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS)	
FLORIDA MEDICAID **COMMUNITY BEHAVIORAL HEALTH AGENCY SERVICES** Reference: Florida Medicaid Community Behavioral Health Services Coverage And Limitations Handbook, AHCA March 2014	**FLORIDA MEDICAID** **MENTAL HEALTH TARGETED CASE MANAGEMENT AGENCY SERVICES** Reference: Florida Medicaid Mental Health Targeted Case Management Handbook, AHCA December 2007

UPLOAD PICTURES INSTRUCTIONS TAKE CLEAR PICTURES OF THE STATE IDENTIFICATION CARD / DIVER LICENSE/ INSURANCE CARD FRONT AND BACK.	
FRONT	**BACK**
Click on the gray area. **Look for your picture folder.** **Select the front side.**	**Click on the gray area.** **Look for your picture folder.** **Select the back side.**
DELETE ALL PATIENT / CLIENT PHOTOS FROM YOUR DEVICE	

MOBILE SCANNING APPS RECOMMENDATIONS	
SCANNER APPS FOR MOBILE DEVICES HELP YOU CAPTURE IMAGES SUCH AS STATE IDENTIFICATION CARDS / DIVER LICENSES / INSURANCE CARDS, MEDICAL RECORDS, AND OTHER DOCUMENTS WITH MINIMAL DISTORTION WITHOUT THE NEED FOR A CUMBERSOME DESKTOP SCANNER.	
Microsoft Lens: Free at Microsoft	**PhotoScan: Free at Google Photos**
DELETE ALL PATIENT / CLIENT PHOTOS AND DOCUMENTS FROM YOUR DEVICE	