FORM 1018

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

(BH)

Hawaii–Medicaid
P.O. Box 2561
Honolulu, Hawaii 96804-2561

REQUEST FOR EXTENSION OF PSYCHIATRIC OUTPATIENT VISIT

NOTE: INCOMPLETE FORM WILL DELAY THE AUTHORIZATION PROCESS: Approval of this request is not an authorization for payment or an approval of charges. Payment by the Medicaid Program is contingent on the patient being eligible and the provider of service being certified by Medicaid. The provider of service must verify patient eligibility at the time the service is rendered.

Medicaid ID Number	Patient's Name (Last, First, M.I.)	Date of Birth ❑ M ❑ F
Print Patient's Mailing Address (St., City, Zip)		
AXIS I		
AXIS II		
AXIS III		
AXIS IV		
AXIS V Current:		Past year:
Current Psychiatric/Psychological Findings (Subjective and Objective) For Substance Abuse, submit a copy of ASAM placement criteria.		
Prognosis		
Reason for Extension		
Treatment Plan/Goal		
Services to be provided by: ❑ Requesting Psychiatrist ❑ Requesting Psychologist ❑ Requesting LSW ❑ Requesting APRN ❑ DOH Clinic Staff		

Print Provider's Name	Signature of Provider Date
Provider Number of Treating Provider	Contact Name
Note: To help prevent overlapping approvals, be sure to fill in the "from" and "to" dates of the last extension approved. Last Extension (if any) Approved: From: To:	Telephone Number
Number of Visits/Hours Used on Last Extension: Visits: Hours:	Fax Number

To be completed by Psychiatrist/Psychologist/LSW/APRN

# of Therapy Visits Requested	Period Requested	Procedure Codes
# Individual visits:	From: To:	CPT
# Group Visits:	From: To:	CPT
# Family Visits:	From: To:	CPT