ABH Single Case Agreement (SCA) Request Form

Submit the completed form by secure email to ABHContracting@LifeViewGroup.org.

Complete all applicable fields. Incomplete requests or requests submitted without sufficient clinical documentation may require follow-up and may delay review.

Requesting Agency/Facility: _____

Billing Provider Medicaid ID: _____

Billing Provider Group NPI: _____

Billing Provider (TIN/EIN): _____

Requestor Name: _____

Telephone Number: _____

Email Address: _____

Licensed Rendering Provider:	Florida License #	NPI:	Medicaid Provider Number:

Member(s) Information:

Please complete the information below for **every member** in need of services.

Requested Start Date:				
Primary Diagnosis (may be provisional on an intake):				
Member's Name	**Medicaid ID:**	**DOB:**	**City of Residence:**	**Place of Service:** (Home, School, Office, Community, Telehealth)
Presenting Problem(s) and how this case meets criterion for a single case agreement: (Must demonstrate the service is necessary to meet the needs of the individual and cannot be reasonably provided by an in-network provider):				

For Molina Continuity of Care requests, please attach the previously implemented Sunshine State Health Plan service agreement.

Services Requested: **Instructions**: Select the services required to meet the collective needs of all members included in the application, not on an individual member basis.	**Assessment Services:** ☐ H2000 HP Psychiatric Evaluation by a Physician * ☐ H2000 HO Psychiatric Evaluation by a Non-Physician ☐ H2010 HO Brief Behavioral Status Exam* ☐ H2000 Psychiatric Review of Records * ☐ H0031 HO In-depth Assessment New Patient MH * ☐ H0031 TS In-depth Assessment Established Patient MH * ☐ H0001 HO In-depth Assessment New Patient SA * ☐ H0001 TS In-depth Assessment Established Patient SA * ☐ H0031 HN Bio-psychosocial Assessment MH * ☐ H0001 HN Bio-psychosocial Assessment SA * ☐ H2019 Psychological Testing (****Requires Prior Auth**) ☐ H0031 Limited Functional Assessment MH* ☐ H0001 Limited Functional Assessment SA* **Treatment Plan Development & Modification:** ☐ H0032 Treatment Plan Development MH ☐ H0032 TS Treatment Plan Review MH ☐ T1007 Treatment Plan Development SA ☐ T1007 TS Treatment Plan Review SA **Behavioral Health Therapy Services:** ☐ H2019 HR Individual and Family Therapy* ☐ H2019 HQ Group Therapy* ☐ H2017 Psychosocial Rehabilitation Services ☐ H2019 HO Therapeutic Behavioral Onsite Services; Therapy ☐ H2019 HN Therapeutic Behavioral Onsite Services; Behavior Management ☐ H2019 HM Therapeutic Behavioral Onsite Services; Therapeutic Support ☐ T1017 HA Targeted Case Management for Children (birth through age 17) * ☐ T1017 Targeted Case Management for Adults (18 years or older) * **Medical & Psychiatric Services:** ☐ T1015 Medication Management * ☐ H2010 HE Brief Individual Medical Psychotherapy MH * ☐ H2010 HF Brief Individual Medical Psychotherapy SA * ☐ H2010 HQ Brief Group Medical Therapy ☐ T1023 HE Behavioral Health Medical Screening MH ☐ T1023 HF Behavioral Health Medical Screening SA ☐ H0046 Behavioral health—related medical services: verbal interaction MH * ☐ H0047 Behavioral health—related medical services: verbal interaction SA * ☐ T1015 HE Behavioral health-related medical services: medical procedures MH ☐ T1015 HF Behavioral health-related medical services: medical procedures SA ☐ H0048 Behavioral health-related medical services: alcohol and other drug screening specimen collection ☐ H0020 Medication-Assisted Treatment Services ☐ OTHER:_____ * **Plus an added GT modifier for telehealth and using POS 10 if received in member's home or POS 02 if received elsewhere.**

Attachment 1:
If serving/requesting agreements for multiple members

Member's Name	Medicaid ID:	DOB:	City of Residence:	Place of Service: (Home, School, Office, Community, Telehealth)