# Mobile Treatment-Child & Adolescent-Initial Request

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## MOBILE TREATMENT-CHILD & ADOLESCENT-INITIAL REQUEST

Is this a telephonic request? (INTERNAL OPTUM USE ONLY)**
○ Yes ◉ No

### Provider Information

Provider Contact Name:* | Provider Contact #:* | Provider Contact Extension | Provider Contact E-Mail:*

### Request Information

Diagnosis:*

Describe participant's current clinical presentation:*

Is the participant is at-risk for out-of-home placement?**
○ Yes ○ No

Describe participant's participation in community mental health services:*

Is the participant exhibiting behavior that is a risk of harm to self or others?**
○ Yes ○ No

Does the primary caretaker support maintaining the participant safely in the home?**
○ Yes ○ No

Does the primary caretaker agree to participate in mobile treatment services?**
○ Yes ○ No

Provide any additional information relevant to this request:

Data Capture Required:
○ Yes

***Please note this authorization request is not a guarantee of payment, coverage is still subject to applicable State of Maryland benefits.***