TCM
Eligibility Request Form

Approval #: _____

Date of Request				
Person Completing Request (please print)				
Recipient Name (Last, First, MI)				
Date of Birth				
Street address				
City, State, Zip				
Phone Number				
Medicaid ID#				
Diagnoses (must use ICD10)				
1.	Substance Use	or	MH	(circle one)
2.	Substance Use	or	MH	(circle one)
3.	Substance Use	or	MH	(circle one)
4.	Substance Use	or	MH	(circle one)
5.	Substance Use	or	MH	(circle one)
6.	Substance Use	or	MH	(circle one)

Diagnostic Summary (per Diagnoses listed above):

1.

2.

3.

4.

5.

6.

Units Used Per Month	
Year:	
J	
F	
M	
A	
M	
J	
J	
A	
S	
O	
N	
D	

ASAM level of care recommended			
ASAM level of care placement			
Rational for deviation			
ASAM on file	Yes	No	(circle one)

TCM SERVICES Request Approved

Level of Care Recommended: _____ Hours Authorized (per month): _____ Units: _____

Begin Date: _____ End Date: _____

Approved Request Cannot exceed 90 calendar days

Approved by: _____ Date: _____