Clear Form

Intensive Community Based Services
Notification Form

Your Facility name: _____

Name of Provider who met with client: _____

Provider phone number: _____

Date of request/notification: _____

Client Name: _____ DOB: _____

Group number and ID: _____

Parent/Guardian Name if a minor: _____

Address: _____

Diagnosis: _____

Current Client Needs and/or reason for referral: _____

Additional Info: _____

Authorization start date: _____

Number of months requested: _____

You will be receiving a call from Medica Behavioral Health with authorization information along with an authorization letter.

Please mail, fax, or email this fully completed form to:

Medica Behavioral Health
Attn: UBH Retro Review
P.O. Box 1459 MN101-E700
Minneapolis, MN 55440-1459
Fax: 1(855-454-8155)
Email: mbh-stcm@optum.com