

Outpatient Mental Health/Chemical Dependency Utilization Review

Required information

Please complete the following required information or verify that all clinical information is included and submitted. Then upload this form to your provider portal at nyceppo.com.

From _____ Phone # _____

Reference # _____ Fax # _____

Patient name _____ Date of birth _____

MM/DD/YYYY

Provider name _____ Credentials _____

Address _____

City _____ State _____ ZIP _____

Phone number _____ Fax number _____

Select one In network Out of network

Current symptoms _____

Functional impairment _____

Short-term measurable goals _____

Medications (doses/frequency) _____

CPT code (5-digits). Please indicate the number of sessions desired for each CPT code as follows:

CPT code	Number of sessions	Starting date (MM/DD/YYYY)	Ending date (MM/DD/YYYY)

This notification is regarding the review of clinical information necessary to determine eligibility for benefit coverage as required by the health plan. It is not a guarantee of payment. As always, payment is subject to the health plan's covered benefits in effect at the time services are provided.