MEDICATION MANAGEMENT NOTIFICATION

HARMONY HEALTHCARE
PHONE (702) 405-2225 FAX (702) 366-0269

Client Name:_____ Date of Birth:_____ Age:_____ Gender:_____

Complete Address:_____Phone:_____

PT SSN_____/_____/_____ Insured Name:_____Employer:_____

Primary Insurance: _____ ID#:_____

Secondary Insurance: _____ ID#:_____

Primary Diagnosis (ICD-10/F-Code ONLY):_____ Secondary Diagnosis (ICD-10/F-Code ONLY):_____

Current problems/Functional impairments (please use specific examples of the nature of patient's deficits in everyday living that require continued treatment, including occupational, marital/family, interpersonal/social, school and/or self maintenance; please provide symptoms and behaviors that support the diagnosis below, including severity, frequency, and duration)

_____

_____

_____

_____

Current Medication Therapy (type and dosage): _____

_____

_____

_____

Provider Name & Title (print):_____ Fax #_____

Provider signature (***required***): _____ Date:_____

PLEASE "X" CPT CODES NEEDED:

___ 90792

___ 99213 **Start date** (*must be within 60 days of this submission*): _____

___ 99214

____ (OTHER) _____

PLEASE NOTE: The provider must still verify a recipient's eligibility by contacting the insurance carrier or obtaining online verification of active coverage on the day the service is provided. If you do not verify the eligibility and extent of coverage of each recipient each time services are provided, then you will risk the possibility of nonpayment for your services.