



LOWER HUDSON VALLEY E.A.P



Mental Health & Substance Use Disorder Services

SINGLE CASE AGREEMENT

Individual's name:	Date of birth:
Member ID number:	Individual's phone number:
Ordering provider's name and specialty:	Provider NPI:
Office address:	
Office phone number:	
Services to be provided & CPT code(s):	
Negotiated Rate:	
Authorized By:	Approved By:
Facility name:	Facility NPI:
Facility address:	
Date/date range of service:	
Service requested (include CPT code) Total days requested:	
Diagnosis code(s):	
Place of service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Other _____	

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

*Name and Title of Provider or Provider Representative Completing Form And Attestation (Please Print)

*Date

*The attestation fields must be completed by a provider or provider representative in order for the request to be accepted.