STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

HEALTH SERVICES PROGRAM

PSYCHOLOGIST MANUAL

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

July 19, 1974

TO: ALL PSYCHOLOGISTS

SUBJECT: ADDITIONS AND CHANGES IN PROCEDURE CODES — MANUAL REVISIONS

The attached pages reflect changes in the description of services for Procedure Codes 9060 and additions of Codes 9062, 9063, 9064 and 9065.

Please insert these new pages in your Psychologists Manual and destroy Pages 27 and 28. 26+

FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material needed to assist the provider in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

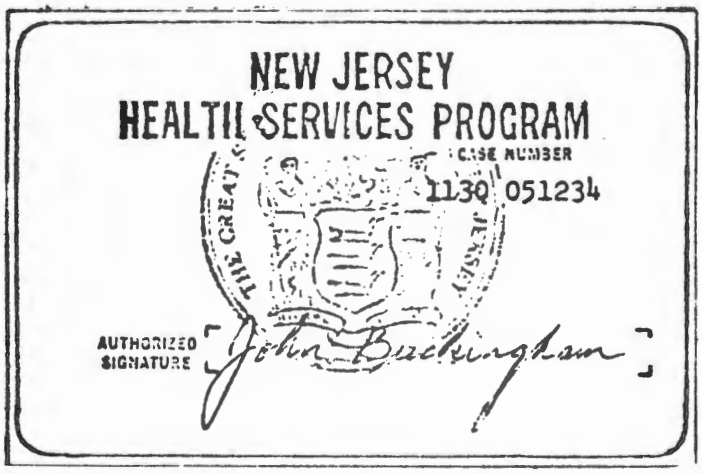
101. HOW TO IDENTIFY A COVERED PERSON

101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OR THE STATE OF NEW JERSEY (SEE SECTION 101.2).

Exhibit I



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

Exhibit II

_____ COUNTY WELFARE BOARD

VALIDATION FOR HEALTH SERVICES PROGRAM

Valid Only for Month of Jan. 1970

BUCKINGHAM 11 30 051234

01 John	24 Olive
02 Mary	25 Sarah
20 Emma Jones	26 Adolph
21 Lila	
22 James	
23 Belinda Smith	

101.3 Temporary Identification and Validation Form (Exhibit III)

In certain circumstances, a temporary identification and validation form will be issued. This form will identify the case as eligible for health services for 30 days from the date of issue.

STATE OF NEW JERSEY
DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TEMPORARY IDENTIFICATION AND VALIDATION OF ELIGIBILITY

CURRENT CASE NO.			EFFECTIVE DATE		
CTY	PROG	NUMBER	MO	DAY	YR

	LAST NAME	FIRST NAME	M.I.	BIRTH DATE		
				MO	DAY	YR

NOTICE TO PROVIDER OF HEALTH SERVICES:

This form, when signed by or on behalf of the person whose name is first listed, identifies the person(s) listed as eligible for payment for authorized health services under the New Jersey Health Serivces Program.

This form also serves as a temporary validation of eligibility for a period not exceeding 30 days from the effective date entered above.

The information appearing on this form should be used in completing the claim form to be submitted to the appropriate Contractor for the State of New Jersey.

NOTICE TO CLIENT:

This form must be signed on the line below marked "Signature" by or on behalf of the person whose name is first listed. This form must be presented to the provider of health services to prove eligibility for payment. DO NOT USE this form after receiving your plastic identification card and your monthly "Validation for Health Services".

Signature _____

Prepared By _____ Date _____

Approved By _____ Date _____

MAP-16(11/69) TEMP. FORM

EXHIBIT III

102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

(a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;

(b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;

(c) Outpatient hospital services;

(d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;

(e) Laboratory and x-ray services;

(f) Skilled nursing home services;

(g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;

(h) Other practitioners' services, limited to Podiatrists, Optometrists, Chiropractors and Psychologists.

(i) Dental services, including dentures;

(j) Home health care services;

(k) Pharmaceutical services - prescribed drugs (legend and non-legend)

(l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;

(m) Rehabilitation services;

(n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transportation.

103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, instituion, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;

Certified Independent Clinical laboratories;

Dentists;

Hearing Aid Dealers;

Home Health Agencies;

Hospitals;

Skilled Nursing Homes;

Opticians;

Optometrists;

Approved Clinics (Independent Outpatient Health Facilities);

Certified Orthotists;

Pharmacies;

Physicians;

Podiatrists;

Certified Prosthetists; (excluding dental)

Providers of Medical Transportation

Chiropractors

Psychologists

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the Local Medical Assistance Unit may assist in obtaining an appropriate practitioner or health resource.

105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

2. When it is customary for persons in the area generally to use medical care resources and facilities outside the State of New Jersey.

3. When out of state care was provided in an emergency.

4. Services rendered by Chiropractors and Psychologists licensed by States other than New Jersey are not eligible for reimbursement under the New Jersey Health Services Program.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;

2. Any services or items furnished in connection with elective cosmetic procedures;

   NOTE: There are certain exceptions to this rule. A written certification of medical necessity and a treatment plan must be submitted by the practitioner to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;

4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;

5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;

6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy (including any benefits payable under the "New Jersey Automobile Reparation Act", P.L. 1972, c.70), any other private or governmental health benefit system, or through any similar third party liability;

7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage:

8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;

9. Any services or items furnished for which the Provider does not normally charge;

10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;

11. Services furnished by an immediate relative or member of the covered person/s household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

   For those individuals who are covered under Medicare, responsibility for payment by the New Jersey Health Services Program will be limited to the unsatisfied deductible to the extent that the payments do not exceed the maximum allowable under the Program in the absence of other coverage.

2. Workmen's Compensation

   No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

   When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

111. MEDICAL REVIEW AND EVALUATION (By Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

116. PROGRAM PARTICIPATION

A. Participation in the Health Services Program of a provider of services is subject to suspension or revocation for good cause shown.

Any of the following shall, inter alia, constitute a good cause for suspension or revocation:

1. Presentment for allowance or payment any false or fraudulent claim for services or merchandise;
2. Submitting false information for the purpose of obtaining greater compensation than that to which he is legally entitled;
3. Submitting false information for the purpose of obtaining authorization requirements;
4. Failure to disclose or make available to the Division or its authorized agent, records of services provided to Medicaid recipients and records of payments made therefore;
5. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by a body of peers;
6. Engaging in a course of conduct or performing an act deemed improper or abusive of the Health Services Program following notification that said conduct should cease;
7. Breach of the terms of agreement of participation entered into with the Division or failure to comply with the terms of providers certification on claim form.
8. Over-utilizing Health Services Program by inducing, furnishing, or otherwise causing an individual to receive service(s) or merchandise not otherwise required or requested by the recipient.
9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral;
10. Violating any provision of P.L. 1968, c. 413, (Health Services Act), or any rule or regulation promulgated by the Commissioner of Institutions and Agencies pursuant thereto;
11. Conviction of any crime involving moral turpitude;
12. Violation of applicable State regulations relating to professional conduct or Code of Ethics.

CHAPTER II
PSYCHOLOGIST'S SERVICES MANUAL

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200. PSYCHOLOGIST SERVICES

201. DEFINITIONS

201.1 Psychologist

"Psychologist" means a practicing professional psychologist who is licensed by the New Jersey State Board of Psychological Examiners. Psychologists practicing in states other than New Jersey are not eligible for reimbursement under the New Jersey Health Services Program.

201.2 Psychological Services

"Psychological Services" means those services rendered within the scope of the profession of psychology as defined by the laws of the State of New Jersey. Psychological services include such services no matter where or in what environment rendered (i.e. office, home, clinic, hospital, mental institution, etc.).

201.3 Psychological Specialist

For purposes of the New Jersey Health Services Program, a Psychological Specialist is an individual, fully licensed by the New Jersey State Board of Psychological Examiners, who limits his practice to his specialty and who:

A. is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified); or

B. has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

201.4 Consultative Services

A consultation is advice or counsel of a qualified specialist as requested by the attending physician. This requires a personal examination of the patient with a written notation of the history, physicial description, diagnosis and recommendations of the consultant.

When the consultant assumes the continuing care of the patient, any subsequent services rendered by him will no longer be considered as consultation (See Section 201.5).

Except where medical necessity dictates, or where hospital policy (therapeutic abortion) or state law (commitment to a mental institution) dictates otherwise, multiple and simultaneous consultations in the same specialty for the same disease, illness or condition, whether in or out of a hospital are not reimbursable. Reimbursement for consultations will be limited to one per specialty per hospital admission.

Consultation services can be paid only when they meet the three criteria of eligible consultation services under the Medicaid Program. To be paid, a consultation must

A. be a professional service furnished to a patient by a psychologist at the request of the attending physician;

B. include a history and examination of the patient;

C. include a written report.

When consultation services are performed in the psychologist's office or the patient's home, the name of the referring physician must be included on the claim form. The name may be listed in Item 13 of that form.

When reporting consultation services, be sure to specify whether they were limited or comprehensive.

201.5 Concurrent Care

In the case of a consultation, the psychologist is entitled to payment for services rendered, subject to limitations under Section 201.4. However, once transfer is made, reimbursement for services can only be made to the current psychologist. Concurrent care will be covered only in an emergency or a significant illness or injury status for which the medical necessity for concurrent care can be clearly established.

201.6 Transfer

Transfer is the relinquishing of responsibility for the continuing care of the patient by one psychologist and the assumption of such responsibility by another psychologist.

202. SCOPE OF REIMBURSABLE SERVICES

Payment will be made for psychological services rendered, subject to the following limitations:

202.1 Hospital Based Psychological Services

In the hospital or similar institution or setting, specific psychologist's services for which the psychologist is reimbursed directly

by the institution under contractual or other arrangements may not be billed and reimbursed on a fee for service basis.

202.2 Hospital Out-Patient Services

All psychological services provided to a patient registered in a hospital out-patient department are considered hospital costs whether or not the psychologist receives compensation from the hospital.

202.3 Services to Persons in Skilled Nursing Homes

When psychological services are provided to persons in a skilled nursing home, payment will not be made for any services rendered by an owner, administrator, stockholder of the company or corporation, or any person who has a direct financial interest in the institution.

202.4 Services Rendered by a Public Mental Health Clinic

Psychological services rendered to any eligible recipient by an approved community mental health agency or by an approved independent outpatient health facility, or under the auspices of such agency or facility, shall not be billed by the psychologist.

203. GENERAL POLICY

203.1 Record Keeping

Psychologists shall keep individual records as may be necessary to disclose fully the kind and extent of services provided and to make such information available as the Division or its agent may request.

For the initial examination, the record shall show the following as a minimum:

A. Date of service rendered.
B. Chief complaint(s).
C. Pertinent historical, social, emotional and attitudinal data.
D. Reports of evaluation procedures undertaken or ordered.
E. Diagnosis.
F. Intended course of procedure and tentative prognosis.

Subsequent progress notes must include date and specific course of treatment undertaken as a minimum.

204. POLICIES RELATED TO INPATIENT CARE

204.1 Hospital Designated Attending Psychologist

If the patient is admitted to a hospital or like institution and does not have a private psychologist, a psychologist may, in accordance with regulations of the hospital's medical and governing boards, be assigned as the psychologist and be reimbursed as such, provided:

A. The patient is allowed free choice of psychologists;
B. The psychologist chosen accepts the professional responsibility for the patient within the scope of his practice.

204.2 Certification and Utilization Review - AID Program

Patients will be admitted to a hospital only on the direction of a physician. Under the Health Services Program, the hospital record of admission will serve as the physician's certification of need. The physician's certification and recertification and utilization committee's approval and reapproval must be on file at the hospital and must be kept available for audit. Certification is not required for outpatient services.

The AID Program (Approval by Individual Diagnosis) is a system whereby the initial number of days of hospitalization approved depends on the diagnosed condition for which the patient is treated.

The regulations of the New Jersey Health Services Program require that the attending physician sign a statement on or before the expiration of AID days (recertification form) certifying the medical necessity of continued hospitalization beyond the AID days.

204.3 Psychologist Responsibility for Discharge Planning

When an inpatient is to be discharged from the hospital and continuing care is required in another medical facility (i.e. skilled nursing facility, intermediate care facility, etc.) or by a community health agency (e.g. Home Health Agency, Visiting Nurses Association, etc.), a legible abstract or summary of those psychological services rendered must be prepared and signed by the psychologist and incorporated in the patient's overall discharge summary. This abstract shall include the patient's hospital course with recommendations for further psychological care, if any, and be made available to the facility, institution or agency to which the patient has been referred.

205. PRIOR AUTHORIZATION

205.1 Prior Authorization

Prior authorization means approval by the Chief, Bureau of Mental Health Services, Division of Medical Assistance and Health Services, of a psychological service by a psychologist before the service is rendered.

Prior authorization is required for:

A. Psychological services exceeding a cost of $300 in any 12-month period commencing with a patient's initial visit when provided in the outpatient's setting with such services being cumulative within that period. (Prior authorization is not required for outpatient psychological services not exceeding $300 under the conditions indicated.)

   Exception: Payment for any psychological services provided to an inpatient in an acute care hospital is excluded from calculation of the $300 limit.

When prior authorization is required, the request is to be submitted in quadruplicate on a "Request for Authorization of Psychiatric Services Form" (FD-07) to the Chief, Bureau of Mental Health Services, Division of Medical Assistance and Health Services, Post Office Box 2486, Trenton, New Jersey 08625.

The patient's name, home address, present address (if different), Health Services Program Number, Patient Person Number, age, sex, beginning date of requested authorization and the psychologist's name, address, etc., is to be inserted on the FD-07 Form.

The request must also include the diagnosis as set forth in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (latest edition), treatment plan and progress report in detail and prognosis. No post facto authorization will be granted.

206. BASIS OF PAYMENT

Reimbursement for covered services furnished under the Health Services Program shall be on the basis of the customary charge prevailing in the community for the same service, not to exceed an allowance determined reasonable by the Commissioner (Institutions & Agencies), and further limited by federal policy relative to payment of practitioners and other individual providers. In no event shall the payment exceed the charge by the provider for identical services to other governmental agencies, or other groups or individuals in the community. If a patient receives care from more than one member of a partnership or corporation in the same discipline, the maximum payment allowance would be the same as that of a single attending physician.

NOTE: Payment for a psychological consultation shall be considered as inclusive for all psychologic services provided, performed or rendered on that day. No additional reimbursement will be allowed for therapy on the day that a consultation is provided.

206.1 Psychological Generalists

Psychologists licensed by the State of New Jersey and approved as providers by the New Jersey Health Services Program shall be reimbursed for allowable psychological testing and psychotherapeutic services to the same extent as a licensed physician (M.D. or D.O.) generalist.

206.2 Psychological Specialists

Psychologists licensed by the State of New Jersey and recognized by the New Jersey Health Services Program as "specialists" in accordance with section 201.3 of this manual shall be reimbursed for allowable psychological testing and psychotherapeutic services to the same extent as a licensed physician (M.D. or D.O.) Specialist as defined in section 201.3 of the Physicians Manual.

CHAPTER III
PSYCHOLOGIST'S BILLING PROCEDURES

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300. BILLING PROCEDURES

This chapter contains basic information necessary for the submission of a claim. Included is a sample claim form approved for use in submitting bills for covered items or services and appropriate instructions for the proper completion of the fomm.

301. GENERAL POLICY

Billing should be done on a monthly basis. Claims for payments of services must be received not later than 90 days following the last date of service as indicated on the claim. For purposes of this time limitation, a claim is a submission in writing, which indicates a request for reimbursement in connection with medical services of a specified nature furnished to an eligible recipient. If a claim, as defined above, is received within the time limit specified, the claim is considered to be filed timely, even though additional information is supplied after the time limitations.

302. PATIENT IDENTIFICATION

Verify that the patient is a covered person on the first visit and each visit therafter. This is done by viewing the patient's Validation Form (See Section 101.) which is issued on the first day of each month. It is especially important to review a patient's Validation Form on each visit when extended plans of treatment have been authorized. Prior authorization is no guarantee that an individual is covered. Authorization becomes invalid upon termination of eligibility.

303. PRIOR AUTHORIZATION

When submitting claims for payment, make certain all authorizations have been properly signed and are attached.

304. COMBINATION MEDICARE/MEDICAID CLAIMS

Services covered under Medicare rendered by non-institutional providers to a Medicare/Medicaid eligible person shall be billed on Form SSA-1490, REQUEST FOR MEDICARE PAYMENT, and the claims sent directly to the Medicare intermediary, Prudential, Medicare B Division, P.O. Box 6500, Millville, New Jersey 08332. The provider must record the Health Insurance Claim Number in Item 2 and the New Jersey Health Services Case and Person Number in Item 5 on SSA-1490. (See Exhibit I)

NOTE: In cases where prior authorization is required for the Health Services Program, it must be obtained and submitted with the Medicare Claim. Medicare Claim Forms (SSA-1490) may be obtained from Prudential.

305. DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS (LMAU)

The following is a list of local Medicaid offices (Local Medical Assistance Units or LMAU's), their county of location, their county(ies) of jurisdiction, their addresses and telephone numbers. It should be noted that the first two digits of the Patient's Health Services Program Case Number indicates which LMAU has jurisdiction. NOTE: Prior authorization for psychological services is obtained from the Chief, Bureau of Mental Health Services, Post Office Box 2486, Trenton, New Jersey 08625, not from the LMAU.

1st Two Digits of HSP Case No.	County	Street Address	Municipality	Zip Code	P.O. Box	Telephone
01, 44	Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1970	609-344-2861
05	Cape May	" " "	" "	"	"	" " "
02	Bergen	50 Main Street	Hackensack	07601		201-488-5667
03, 45, 46	Burlington	Chesley & Alloway Bldg. Rt. 38 & Eayrestown Rd.	Mt. Holly	08060		609-261-0448
04, 34	Camden	530 Cooper Street	Camden	08101	19	609-365-3926
06, 41	Cumberland	7 E. Broad Street	Bridgeton	08302	440	609-451-6550
07	Essex	796 Broad Street	Newark	07101	1576	201-648-2470
08	Gloucester	42 Delaware Avenue	Woodbury	08096	1900	609-845-718[illegible]
17	Salem	" " "	"	"	"	" " "
09	Hudson	100 Newkirk Street	Jersey City	07306		201-792-6390
10, 35, 48	Hunterdon	6 Court Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"		" " "
21	Warren	" " "	"	"		" " "
11, 32, 90	Mercer	324 E. State Street	Trenton	08625	2465	609-292-7315
12, 47	Middlesex	75 Paterson Street	New Brunswick	08903	1274	201-246-0653
13, 33, 36	Monmouth	320 Broad Street	Red Bank	07701		201-842-6440
14, 31	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	"	"		" " "
15	Ocean	1851 Hooper Ave.	Toms River	08753		201-255-6226
16, 42	Passaic	152 Market Street	Paterson	07509	2863	201-523-2800
20	Union	7 Bridge Street	Elizabeth	07201		201-355-8860

305.1 Eligibility Questions

Medicaid eligibility is determined by four (4) different agencies (e.g., County Welfare Boards, Bureau of Local Operations of the New Jersey Division of Public Welfare, New Jersey Division of Youth and Family Services, and the Federal Social Security Administration).

Provider inquiries concerning patient eligibility and/or applications for eligibility may be directed to the appropriate Eligibility Determination Agency (if known by the provider) or to the LMAU serving the provider's area. The LMAU will assist the provider by answering the questions and/or directing the provider to the appropriate Eligibility Determination Agency.

306. PHYSICIANS AND PRACTITIONERS CLAIMS (MC-8)

This form is used for the purpose of billing for covered services of physicians, podiatrists, optometrists, psychologists and chiropractors. Billing should be done on a monthly basis and submitted for payment as soon after the end of the month as is possible.

306.1 Instructions for Completion of Form MC-8 (See Exhibit II)

1-4. NAME, ADDRESS, CASE NO., AND PERSON NO. - Copy Patient's Name, H.S.P. Case Number and Patient Person Number EXACTLY as it appears on the Validation Form (See Section 101.).

5-6. Self-explanatory.

7. OTHER INSURANCE OR LIABILITY COVERAGE - If patient has other Health Insurance or Liability Coverage, check appropriate block, and attach copy of explanation of payment from the carrier.

8. EMPLOYMENT RELATED - If patient's illness or injury is work related enter name and address of employer.

9. NAME AND ADDRESS OF PROVIDER - (This information may be preprinted).

10. Self-explanatory.

11. Write in Name of institution, if place of service is other than doctor's office or patient's home. To be completed in addition to Question 12B.

12. REPORT OF SERVICES -

A. Enter date(s) of each visit.
B. Place of service (see codes at bottom of claim form).
C. Enter diagnosis.
D. If the service rendered can be identified by a code (See Chapter IV) only the code number need be listed, it is not necessary to supply a code number and description. If a code is not provided in Chapter IV for the service rendered, enter a description of the service.
E. Not Applicable
F. Enter your usual and customary charge for each service or procedure.

13. CONSULTATION - Provide full name of referring physician for consultations.

14. PATIENT'S CERTIFICATION - Under ordinary circumstances, the patient must sign the claim form when services have been received. The claim form to be signed should indicate service rendered, and the patient must not sign a blank claim form prior to receiving services or as a condition for receiving services.

    However, when the patient's signature is unobtainable, the following procedures may be used:

    a. Illiterate Patient
    The patient may sign by mark (X), and the signature must be witnessed by another person including the provider of service who signs his name and address on the same line.

    b. Other
    If a patient is physically or mentally incapable of signing, a minor child, deceased, or for other reasons the patient's signature is not obtainable, through reasonable effort, the form may be signed on his behalf by:

    (1) A parent, or
    (2) A legal guardian, or
    (3) A relative, or
    (4) A friend, or
    (5) An individual provider, or
    (6) A representative of an institution providing care or support, or
    (7) A representative of a governmental agency providing assistance.

    Attached to the claim form or written directly on the form should be a brief explanation of reason patient was not personally able to sign and relationship of signee to the patient-recipient.

15. PROVIDER'S CERTIFICATION - The provider MUST sign and date the form before the claim may be considered.

306.2 Mailing Instructions

Mail the original copy (Contractor's Copy) together with authorization from FD-07 (when appropriate) to:

The Prudential Insurance Company of America
P.O. Box 1900
Millville, New Jersey 08332

REQUEST FOR MEDICARE PAYMENT

EXHIBIT I

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—**Type or Print Information**)

Form Approved
Budget Bureau No.
72-R0730

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:

Copy from YOUR OWN HEALTH INSURANCE CARD (*See example on back*)

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number Letter

☐ Male ☐ Female

3 Patient's mailing address City, State, ZIP code Telephone Number

4 Describe the illness or injury for which you received treatment (*Always fill in this item if your doctor does not complete Part II below*)

Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.

Insuring organization or State agency name and address

Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient (*See instructions on reverse where patient is unable to sign*)

SIGN HERE

Date signed

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (*If related to unusual circumstances explain in 7C*)	Leave Blank
				$	

8 Name and address of physician or supplier (*Number and street, city, State, ZIP code*)

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill (*See reverse*)

☐ I accept assignment and will accept the charge determination of the Medicare carrier as the FULL charge.

☐ I do not accept assignment.

13 Show name and address of facility where services were performed (*If other than home or office visits*)

14 Signature of physician or supplier (*A physician's signature certifies that physician's services were personally rendered by him or under his personal direction*)

☐ MD ☐ DO ☐ DDS

Other degree _____

Date signed

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home (*If portable X-ray services, identify the supplier*)
IH—Inpatient Hospital
ECF—Extended Care Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

Department of Institutions and Agencies
Division of Medical Assistance and Health Services

PHYSICIANS AND PRACTITIONERS CLAIM

EXIBIT 2

03

1. Patient's Last Name First Name

2. Patient's Street Address | Telephone Number

3. Health Services Program Case No.

4. Patient Person # | 5. Age | 6. Sex M/F

City State ZIP Code

7. Other Health Insurance or Liability Coverage? Yes No
If Yes, attach copy of Explanation of Payment from carrier. (If Medicare — See Section 304 of Manual)

8. Was Patient's Illness or Injury connected with his employment? Yes No
If Yes, give Name and Address of Employer here.

9. PROVIDER OF SERVICE INFORMATION

Social Security or Employer I.D. Number (Enter only when not printed below)

10. Did injury result from automobile accident? Yes No

Name and Address

11. Give Name of Institution if Place of Service is other than Doctor's Office or Patient's Home.

Telephone Number

FOR CONTRACTOR'S USE ONLY

TOTAL AMOUNT A	TOTAL AMOUNT B	CODE	JAM	HOSPITAL PROVIDER NUMBER

12. REPORT OF SERVICES
1—Doctor's Office 2—Patient's Home 5—Skilled Nursing Home 6—Independent Laboratory 9—Other Locations (Specify in 12C) 0—Emergency Room
3—Inpatient Hospital 4— 7—Outpatient Hospital 8—Clinic (Other than Hospital based)

A. DATE OF EACH VISIT	B. PLACE OF SERV.	C. NATURE OF ILLNESS OR INJURY REQUIRING SERVICES	D. FULLY DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE OF SERVICE	E. CHECK (✓) IF FAMILY PLANNING	F. CHARGE
					$

13. IF CONSULTATION — Give Name of Referring Physician

TOTAL CHARGES $

14. PATIENT'S CERTIFICATION. Authorization to Release Information, and Payment Request. I certify that the service(s) covered by this claim has been received, and I request that payment for these services be made on my behalf. I authorize any holder of medical or other information about me to release to the Division of Medical Assistance and Health Services or its authorized Agents any information needed for this or a related claim.
Signature (Patient or authorized representative) Date Signed

15. PROVIDER CERTIFICATION. I certify that the services covered by this claim were personally rendered by me or under my direct personal supervision (as defined by Program regulations); that the foregoing information is true, accurate and complete; and I agree to keep such records as are necessary to disclose fully the extent of services provided, and to furnish information for such services as the State agency may request; and that the services covered by this claim and the amount charged therefore are in accordance with the regulations of the New Jersey Health Services Program; and that no part of the net amount payable under this claim has been paid; and that payment of such amount will be accepted as payments in full without additional charge to the patient or to others on his behalf. I also certify that the services have been furnished in full compliance with the non-discrimination requirements of Title VI of the Federal Civil Rights Act. I understand that fraud or concealment will be punishable under applicable Federal or State law, or both.
Provider Signature ☐MD ☐DO Date Signed
Other Degree _____

FOR PAYMENT MAIL TO: The Prudential Insurance Co. of America — P.O. Box 1900 — Millville, N.J. 08332

FOR CONTRACTOR'S USE ONLY

CARD	DATES OF SERVICE FROM YR	FROM MO	FROM DAY	TO MO	TO DAY	PLACE	TYPE	R=0 & P=1	# OF VISITS	PROC	VALUE	AMOUNT A	AMOUNT B	CODE	JAM	DATE RECEIVED YR	JULIAN DATE	CODER I D
B																		
H																		

CARD	PROCEDURE CODE (1)	PROCEDURE CODE (2)	PROCEDURE CODE (3)	PRIMARY DX.	SECOND DX.	
B						PATIENT
H						PROVIDER

STATE OF NEW JERSEY
Department of Institutions and Agencies
Division of Medical Assistance and Health Services

Request for Authorization of Psychiatric Services

EXHIBIT III

1. Patient's last name	First name	2. Patient's street address	Telephone number

3. Patient's services program case no.	4. Patient Person #	5. Age	6. Sex ☐ Female ☐ Male	City,	State	ZIP code

7. Patient's present address if different from above.	Telephone number

8. Past psychiatric history

9. History of Present Psychiatric Illness or Interim Progress Report (Include the date patient first consulted you. If additional space is needed, please use reverse side).

10. Diagnosis (Must conform with Diagnostic and Statistical Manual II)

11. Treatment Plan

a. Chemotherapy Yes..... No..... If yes, specify medication (include dosage, route and frequency of administration, length of time on RX)

b. Psychotherapy Yes..... No..... If yes, complete applicable information below.

Group ..... (Maximum of 8 patients, minimum session 1½ hours) Frequency of sessions.....

Individual..... Frequency of sessions..... Length of sessions: Full (60 min.)..... Half (30 min.).....

Describe type of psychotherapy used: .....

.....

Other types of therapy: (Specify).....

.....

Effective beginning date of requested services ..... Anticipated duration of treatment ..... months. Prognosis .....

.....

Reimbursement is to be within the limits of the Program and will not be made for broken appointments or for periods when eligibility is not current.

12. From: Name and address of provider	Social Security or Employer I.D. number	Telephone number
	Provider signature	Date

For Office Use Only

Authorization

TO: .....: You are authorized to submit a request for payment for .....

..... which shall commence ..... and terminate .....

Date .....

.....
Chief, Bureau of Mental Health Services

FD-07
Printed in U.S.A.
Medicaid 34157 Ed 2-72

PSYCHOLOGICAL SERVICES MANUAL

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

INDEX

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:67-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this Subchapter 3. are relevant to Medicaid psychological services and must be used when filing a claim.

(b) GENERAL POLICIES REGARDING USE OF HCPCS CODES

Listed below are some of the general policies of the New Jersey Medicaid Program regarding HCPCS. (The responsibility of the psychologist when rendering services and requesting reimbursement is listed in both Subchapter 1. and Subchapter 2. (Billing Procedures).

1. The use of a procedure code will be interpreted by the New Jersey Medicaid Program as evidence that the psychologist personally furnished, as a minimum, the service for which it stands.

2. For purposes of reimbursement, a psychologist, psychologists' group, shared health care facility or psychologists sharing a common record are considered a single provider.

3. When billing, the provider must enter into the procedure code column of space 24-D of claim form 1500-N.J. a HCPCS code as listed in this manual. If an appropriate code is not listed, place a "N/A" (not applicable) in the procedure code column and submit a narrative description of the service. If possible, insert into space 24-D a CPT code closest to the narrative description you have written.

4. It is not the intent of the program to reimburse a psychologist for histories and/or psychological examinations performed by physician assistants, interns, residents or other house staff.

i. For reimbursement purposes, when reference is made to any of the following services it is understood that they were performed by the psychologist submitting the claim:

(1) Office, Hospital, Nursing Home, or Sheltered Boarding Home Visits.

(2) Any part of a history or psychological examination.

ii. To qualify as documentation that the service was rendered by the psychologist during an inpatient stay, the medical record must contain the psychologist's notes indicating that he/she personally:

(1) Reviewed the patient's history with the patient and/or his family, depending upon the medical situation.

(2) Performed a psychological examination.

(3) Confirmed or revised the diagnosis.

(4) Visited and examined the patient on the days for which a claim for reimbursement is made.

iii. In a hospital, long-term care facility or group practice settings, such medical records as noted above must be signed by the psychologist providing the services.

(1) The billing psychologist's involvement must be clearly demonstrated in notes reflecting his/her personal involvement with the service rendered. This refers to those occasions when these notes are written into the medical record by interns, residents, other house staff members, or nurses. A countersignature alone is not sufficient.

5. Date(s) of service(s) must be indicated on the claim form and in the psychologist's own record for each procedure code submitted for reimbursement.

6. When submitting a claim, the psychologist must always use his/her usual and customary fee. The MEDICAID DOLLAR VALUE designated for the HCPCS codes represents the New Jersey Medicaid Program's maximum payment for the given procedure.

i. All references to time parameters shall mean the psychologist's personal time in reference to the service rendered unless it is otherwise indicated.

10:67-3.2 HCPCS CODES FOR PSYCHOLOGICAL SERVICES

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE S	$	NS
NOTE:	Only under exceptional circumstances will more than one mental health procedure be reimbursable per day for the same recipient by the same provider, group, shared health care facility, or practitioners sharing a common record.			
W9105	PSYCHOLOGICAL DIAGNOSTIC INTERVIEW EXAMINATION BY A PSYCHOLOGIST, including history, mental status, or disposition (may include communication with family or other sources, ordering and interpretation of other psychodiagnostic studies). In certain circumstances other informants will be seen in lieu of the patient. Consultation for psychological evaluation of a patient, includes examination of a patient and exchange of information with referring person or agency. NOTE: Will require for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member. NOTE: No more than one diagnostic interview examination is reimbursable per year for the same recipient by the same psychologist.	37.		26.
W9113	INDIVIDUAL PSYCHOTHERAPY, BY A PSYCHOLOGIST, with continuing psychological diagnostic evaluation including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy. Time 25 minutes.	19.		13.
W9114	INDIVIDUAL PSYCHOTHERAPY BY A PSYCHOLOGIST, with continuing psychological diagnostic evaluation including psychoanalysis, insight oriented, behavior modifying or supportive psychotherapy. Time 50 minutes.	37.		26.
W9115	GROUP PSYCHOTHERAPY, BY A PSYCHOLOGIST, requires a minimum of 90 minutes of direct clinical involvement with the patient as a member of a group, of which 10 minutes can be used for documentation. The maximum number of the group is 8 and the reimbursement is per person per group session.	8.		6.

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE S	$	NS
W9116	INTERPRETATION or EXPLANATION BY A PSYCHOLOGIST, or results of psychological examination and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient. Time 25 minutes. (Formerly Family Conference) NOTE: This procedure must be used as an adjunct to treatment of patient or client and is subject to prior Authorization and billing as part of patient's treatment.	19.		13.
W9117	FAMILY PSYCHOTHERAPY BY A PSYCHOLOGIST, (conjoint psychotherapy) with continuing psychological evaluation. Time 50 minutes.	37.		26.
W9118	FAMILY PSYCHOTHERAPY BY A PSYCHOLOGIST, (conjoint psychotherapy) with continuing psychological evaluation. Time 80 minutes.	46.		32.
10:67-3.3 HCPCS CODES FOR PSYCHOLOGICAL TESTING				
W9130	Bayley Scale of Infant Development	48.		34.
W9131	Bender Visual - Motor Gestalt Test	15.		10.
W9132	Benton Bisual Retention Test	15.		10.
W9133	Blacky Pictures	30.		21.
W9134	Cattel Infant Intelligence Scale	48.		34.
W9135	Children's Apperception Test	30.		21.
W9136	House - Tree - Person	22.		15.
W9137	Human Figure Drawing (Draw-A-Person)	15.		10.
W9138	Kinetic Drawings	15.		10.
W9139	Merrill-Palmer Scale	37.		26.
W9140	Michigan Picture Test	30.		21.
W9141	Minnesota Developmental	48.		34.
W9142	MMPI (machine scored)	22.		15.
W9143	Peabody Picture Vocabulary Test	18.		13.

HCPCS CODE	DESCRIPTION	MEDICAID DOLLAR VALUE S	$ NS
W9144	Projective Drawings	15.	10.
W9145	Raven's Progressive Matrices (1938)	30.	21.
W9146	Raven's Progressive Matrices (1947)	18.	13.
W9147	Rorschach (or Holtzman) Inkblots	55.	39.
W9148	Sentence Completion (any form)	15.	10.
W9149	School Apperception Method	30.	21.
W9150	Slosson Intelligence Scale	18.	13.
W9151	Stanford - Binet	55.	39.
W9152	Symonds Picture Story Test	30.	21.
W9153	Thematic Apperception Test	30.	21.
W9154	Vineland Social Maturity Scale	37.	26.
W9155	Wechsler Adult Intelligence Scale	55.	39.
W9156	Wechsler Intelligence Scale for Children	55.	39.
W9157	Wechsler Intelligence Scale for Children-Revised	55.	39.
W9158	Wechsler Primary & Preschool Intelligence Scale (WPPSI)	55.	39.
W9159	Wechsler Memory Scale	26.	18.
W9160	Wide Range Achievement Test	18.	13.
W9161	Other (By Report)		

MEDICAID *BULLETIN*

NEW JERSEY HEALTH SERVICES PROGRAM

DATE: January 11, 1981

TO: Physicians and Psychologists

SUBJECT: Revised FD-07 (Rev. 10/81) "Request For Authorization of Health Services".

Please include the attached FD-07 form, "Request For Authorization of Mental Health Services" with Newsletter Volume P-325, dated January 4, 1982.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA (GOVERNMENTAL HEALTH PROGRAMS DEPARTMENT)
P.O. BOX 1900 • MILLVILLE, NEW JERSEY 08332

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

REQUEST FOR AUTHORIZATION OF MENTAL HEALTH SERVICES

PATIENT INFORMATION

1. PATIENT'S NAME	2. HEALTH SERVICE PROGRAM NO.	3. PATIENT PERSON NO.	4. AGE	5. SEX ☐ M ☐ F
6. STREET ADDRESS	7. CITY, STATE, ZIP			8. TELEPHONE NUMBER
9. PLACE OF SERVICE - NAME AND ADDRESS		10. ATTENDING PHYSICIAN'S (Signature) IF ITEM 9 IS A LTCF		

CLINICAL INFORMATION

11. BRIEF CLINICAL HISTORY

12. PRESENT CLINICAL STATUS (TO SUPPORT REQUEST)

13. DIAGNOSIS AND CODE (MUST CONFORM WITH DIAGNOSTIC AND STATISTICAL MANUAL III)

SERVICE REQUEST

14. TREATMENT REQUEST	FREQUENCY-INDICATE NUMBER			LENGTH OF SESSION - CHECK				
	PER WEEK	PER MONTH	PER YEAR	1½ HR	1 HR	½ HR	1 DAY	½ DAY
A. PSYCHOTHERAPY, INDIVIDUAL								
B. PSYCHOTHERAPY, GROUP								
C. FAMILY THERAPY								
D. FAMILY THERAPY/CONFERENCE								
E. PARTIAL HOSPITALIZATION								
F. PARTIAL CARE								
G. MEDICATION MANAGEMENT								

H. PSYCHOLOGICAL TESTING, BY CODE NUMBER: _____

15. DURATION OF THIS SERVICE BLOCK:

STARTING DATE: NUMBER OF MONTHS:

PROVIDER

16. NAME AND ADDRESS OF PROVIDER	17. IMP NUMBER	18. TELEPHONE NUMBER
PROVIDER NO.	19. PROVIDER SIGNATURE	20 DATE: / /

FOR DIVISION USE ONLY - The following services are authorized not in excess of:

PSYCHOTHERAPY, INDIVIDUAL	1 HOURS		½ Hour		PARTIAL HOSPITALIZATION	1 DAY		½ DAY	
PSYCHOTHERAPY, GROUP	1½HOURS				PARTIAL CARE	1 DAY		½ DAY	
FAMILY THERAPY	1½HOURS				MEDICATION MANAGEMENT				
FAMILY THERAPY/CONFERENCE	1 HOUR		½ HOUR		PSYCHOLOGICAL TESTING				

AUTHORIZATION

Reimbursement is to be within the limits of the program and will not be made for broken appointments or for periods when eligibility is not current.

COMMENTS: _____

THIS AUTHORIZATION PERIOD FROM: _____ THRU _____

DATE _____ AUTHORIZING SIGNATURE _____ TITLE _____