Submit Fax Request To: Behavioral Health Program
507-431-6329 (Fax)

MH-TCM Eligibility Notification Form

Type of Request		
Instructions: 1. For Initial or Annual Notification for MH-TCM, submit this form. 2. SCHA will request the Diagnostic Assessment, Functional Assessment, ICSP, IFCSP, case notes, etc. on an as needed basis.		
Authorization Request		
☐ Initial Notification	☐ Renewal Notification	
Billing / Eligibility Information		
First SCHA MH-TCM Billing Date (list specific date):	Date member most recently opened to MH-TCM Services:	
☐ This is a court ordered civil commitment case. *Must Submit Pre-Petition Screening and Full Court Order	Date of Commitment: Date of Continuation of Commitment:	
☐ Member has transitioned to South Country Health Alliance from another health plan on:		
Diagnostic Assessment Information:		
☐ Brief ☐ Standard / Extended DA	Date of most recent DA: Primary Diagnosis Code(s):	
Has there been a break in MH-TCM service? ☐ No ☐ Yes , If Yes →	Date closed: Date re-opened:	
☐ No ☐ Yes Has there been continued MH-TCM services in lapse of a DA? *Please include information with Notification Form to justify continued services.		
☐ No ☐ Yes Member has transferred MH-TCM Services to another servicing provider? →	If yes; Please list the previous provider:	
☐ No ☐ Yes New MH-TCM Member whom refused an Initial DA. *Must be submitted within 30 days of request for presumptive.		
☐ No ☐ Yes Has there been a marked change in member's mental health status that required a new/updated DA?		
☐ No ☐ Yes Has the child turned 18 years of age since the most recent PA submission?		
Member Information		
Name:		
PMI:		
DOB:		
Address:		
City, State, Zip:		
County of Residence:		
County of Financial Responsibility:		
If member is a child, Legal Guardian Information;		
Legal Guardian Name:		
Address:		
City, State, Zip:		
Case Manager / Provider Information		
MH-TCM Case Manager:		
Provider Organization Name:		
Billing Provider NPI and TIN (Tax ID Number)	NPI:	TIN:
Provider Address:		
Provider City, State, Zip:		
Case Manager Phone / Fax:	Phone:	Fax:
Assurances		
I, Case Manager, attest that the following documents are located in member's file:		
☐ Current Diagnostic Assessment which contains all required elements.		
☐ Or Psychological Evaluation meeting all DA requirements.		
☐ Functional Assessment	☐ Signed ICSP/IFCSP	

South Country Health Alliance
2300 Park Drive, Ste 100
Owatonna, MN 55060

SCHA Behavioral Health Program: 888-633-4051 (Phone)
SCHA Provider Call Center: 888-633-4055 (Phone)

Clear Form