

## State Managed Services Program Request Form

**VERY IMPORTANT INFORMATION:**

- Please read the instructions completely before submitting this request. Instructions can be found on the program website at [www.healthoregon.org/hiv](http://www.healthoregon.org/hiv) . This request must be complete before processing will occur.

**Is this a Provider UPDATE to a previously authorized request?**  Yes  No

If "Yes", only complete questions 1, 2, 7 and 8.

1. Client Name: \_\_\_\_\_

2. Date of Request: \_\_\_\_\_

3. a. Funding Requested For (a separate request must be submitted for each service requested):

Service Requested	Maximum Benefit	Initial Assessment
<input type="checkbox"/> Dental Services Phase 1	Phase 1: \$500	None required
<input type="checkbox"/> Dental Services Phase 2	Phase 2: Local Assessment	A Treatment Plan (from the dental provider listed below) indicating the total charges must be attached. The client will only be authorized for the amount shown on the Treatment Plan up to the maximum benefit. See the SMS program instructions for more information.
<input type="checkbox"/> Substance Abuse Treatment- Outpatient	\$5000	A copy of the Services Plan (from the provider listed below) indicating the total charges must be attached. The client will only be authorized for the amount shown on the services plan up to the maximum benefit. See the SMS program instructions for more information.
<input type="checkbox"/> Substance Abuse Treatment- Residential		
<input type="checkbox"/> Mental Health Services	\$6500	
<input type="checkbox"/> Home Health Care- Professional/Specialized	\$2000	
<input type="checkbox"/> Home Health Care- Paraprofessional		
<input type="checkbox"/> Medical Nutritional Services	\$2500	

3. b. I would like to request payment for the initial assessment (Maximum Benefit = \$300) in order to obtain the required service plan needed to complete this Request Form (does not apply to Dental Services).  Yes  No

*I understand that if I mark "Yes" I will receive two service authorization forms, one for the initial assessment and one after the treatment/service plan has been sent in to the SMS program. Services MUST be pre-authorized by the SMS program.*

4. If the service requested is for Dental Services please indicate the "Dental Acuity" of the client.

Level 1  Level 2  Level 3  Level 4

5. Does the client have any form of health insurance?  Yes  No

If the answer is "Yes" list the insurance provider(s) and indicate whether they will pay a portion of this requested service. *Due to the Mental Health Parity Act mental health and substance use treatment services are covered by most insurance plans. Ryan White funds are the funds of last resort and must be utilized after insurance coverage.*

Health Insurance Provider	Do they cover any portion of this service?
CAREAssist Dental (MODA Delta Dental Plan)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Is there a Federally Qualified Community Health Clinic, Community Health Clinic, Dental Clinic or other community resource in your service area where the client could receive this service?

Yes  No

If the answer is "Yes", AND the service requested is not being performed by this provider, please explain why. \_\_\_\_\_  
\_\_\_\_\_

7. Complete the contact information for the service provider identified. **Please PRINT LEGIBLY.**

Agency/Health Systems/Clinic Name: \_\_\_\_\_

Provider/Doctor Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Yes, this provider **Will** accept VISA® as a form of payment.

No, this provider **will NOT** accept VISA® as a form of payment.

\*If "No", provide the Tax ID number of the provider: \_\_\_\_\_

8. I have referred to the *HIV Medical Case Management Standards of Service/HIV Medical Care Coordination Standards of Service* and the *HIV Case Management and Support Services Program- Program Policies, Services Definitions & Guidance* and have determined that this individual is eligible for the service requested above in item 2. I understand that the first invoice must be received within 90 days of the date of the SMS service authorization.

HIV Case Manager Name: \_\_\_\_\_ County \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX THIS REQUEST TO DHS  
971-673-0177, ATTENTION: SMS**

\*Additional forms can be found on the program website at [www.healthoregon.org/hiv](http://www.healthoregon.org/hiv) .