Mental Health Verification of Services

Member Name: ________________________________
Birth Date: ____________________ ID#: ____________________
Date of Hospital Discharge: ______________________

Ambulatory Mental Health Treatment

I have reviewed the above patient's medical records or claims and confirm that the member was seen on ____________________ (first date following hospital discharge) for treatment of a mental health diagnosis.

Provider Signature: ___________________________________

Please mark the appropriate level of practitioner below:

☐ Psychiatrist ☐ Social Worker ☐ Marital or family therapist
☐ Psychologist ☐ Psychiatric nurse ☐ Licensed or certified counselor

PHP or IOP Treatment:

I have reviewed the above patient's medical records or claims and confirm that the member was seen on ____________________ (first date following hospital discharge) for treatment of a mental health diagnosis.
Please mark the appropriate program below:

☐ PHP ☐ IOP

Signature of Program Staff: ___________________________________
Program Name: _______________________________________

- Either the ambulatory MH treatment section or the PHP or IOP Treatment section must be completed entirely to be accepted.

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