

**CONSUMER INFORMATION UPDATE/REQUEST FOR ADDITIONAL UNITS/SERVICE DATE
CORRECTIONS**

TO: AMHD Utilization Management

DATE:

PHONE NUMBER:
586-7400

FAX NUMBER:
453-6966

Reason for form completion:

- Updated Information Only (If consumer information needs to be updated but no other request is being made, fill out the information below with the Consumer Name, SSN, and Date of Birth then add the changes.)
- Additional Units for: CMO CSM CBCM ACT
- Service Date Corrections for Admission/Continued Stay/Discharge if Different from the Service Authorization Request:

Service: _____ Actual Date: ____/____/____

CONSUMER INFORMATION (Type or Print Clearly)

Name: _____ Alias: _____

Date of Birth: _____ SSN: _____ Phone: _____

Address: _____ City: _____

State: HI Zip Code: _____

Current DX Code, Axis I: _____ Current DX Code, Axis II: _____

Axis III: _____ Axis IV: _____

Axis V: _____

Other Benefit Coverage: _____ Policy #: _____

- Legal Status: 405 404 406 411.1.a 411.1.b
 706-607 413 415 Parole Probation
 VOLUNTARY Other: (Specify) _____

PROVIDER CONTACT INFORMATION

Provider Agency: _____ Submitted by: _____

Case Manager Name: _____ Agency: _____

Provider Phone: _____ Provider FAX: _____

Address: _____ City: _____

State: HI Zip Code: _____

Consumer Update Information/Request for Additional Units/Service Date Corrections

Consumer Name: _____ DOB: ____/____/____

Special Health Care Needs: No Yes

If yes, describe needs: _____

(Examples of Special Health Care Needs include: Deaf, Blind, Non-Ambulatory, Dependence on electricity for such things as dialysis and refrigeration for life sustaining drugs such as insulin or other special environmental circumstances.)

English as Second Language: No Yes, Specify Primary Language: _____

Request for Increased/Additional Units

- Type of Service: _____
- Authorization Number: _____
- Dates of Service: _____
- Number of Additional Units for this Request: _____
- Total Units Requested to Date: _____
- Clinical Justification for Increased Units:

Name and Title of Provider Representative Completing Form (Please Print):

Name _____ Title _____

Phone: _____ FAX: _____

Date Form Completed _____ Signature _____