Companion
BENEFIT ALTERNATIVES

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SC DMH Initial Outpatient Mental Health Treatment Request Form
(South Carolina Department of Mental Health Clinic ONLY)

NOTE: CBA will not accept referrals for psychological testing on this form. Please use the CBA Psychological Testing Pre-Authorization Request Form.

**Required information*

Clinic's Name*: ______________________________ Phone*: ____________________

Mailing Address 1*: ____________________________ Fax*: ____________________

Mailing Address 2: _____________________________ E-mail*: ____________________

City*: ______________________ State*: __________ ZIP Code*: ____________

Clinic's NPI*: ____________________

Contact's First Name: ____________________ Contact's Last Name: ____________________

Contact's Extension*: ____________________

Patient's First Name*: ____________________ **Patient's Last Name***: ____________________

Date of Birth*: ____________________ **ID Card Number*:** ____________________

Phone: ____________________ **E-mail**: ____________________

Patient's CIN: ____________________

What service(s) are you requesting?*

- ☐ MMO – Medically Monitored Only
- ☐ Management & Treatment Services
- ☐ Injectable Track Services

When is the Patient's first appointment?* ____________________

Diagnosis or Presenting Symptoms*:

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Certification is not valid until CBA issues a certification number.

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