Certification of Court Ordered Services for Mental Health / Substance Use

Health insurers must make decisions for mental health and/or substance use disorder services that require preauthorization within 72 hours from receipt of the request if the insured, or the insured's designee, certifies: (1) the insured will appear or has appeared before a court, and (2) a court has or may order the services. This form certifies to a health insurer that a court has or may order mental health and/or substance use disorder services. This form is not a preauthorization request for services. Ask the health insurer who should request preauthorization and if it can be done by telephone. The health insurer will send a preauthorization decision to the insured or the insured's designee, the provider, and if possible, the court.

INSTRUCTIONS:

- Complete 1-10. Attach a copy of the court order if one has been issued and is available.
- Send this form to the insured's provider and to the insurer.
- For questions, contact the Department of Financial Services at (800) 400-8882 or the health insurer.

1. **Name of insured** receiving the services:	
2. Address, phone number & email address of insured:	
3. Name of health insurer:	
4. Insured's health insurance ID#:	
5. Name, address, phone number & email address of insured's designee (if the insured has a designee):	
6. Name, address & phone number of court:	
7. Name, address & phone number of treating provider:	
8. Describe the insured's medical condition & requested treatment:	
9. **Circle A or B** and insert date. I certify that I/the insured:	
(A) am/is scheduled to appear before a court on _____ (insert date) and may be subject to a court order requiring mental health and/or substance use disorder services.	
(B) appeared before a court on _____ (insert date) and may be subject to a court order requiring mental health and/or substance use disorder services.	
10. If you are the insured sign (A). If you are the insured's designee sign (B)	
(A) I certify that the information provided in this form is accurate to the best of my knowledge.	
Signature of insured:	
(B) I certify that the insured requested me to act on his or her behalf and that the information provided in this form is accurate to the best of my knowledge. I am aware if the insured does not sign this form, the insurer may request proof that the insured designated me to act for him/her. In addition, if the insured wants the insurer to disclose the insured's substance use disorder treatment information to me, the insured may need to complete a separate authorization allowing the disclosure.	
Signature of insured's designee:	