

65M&N Assessment Authorization Change Request Form

Date of Request: _____

Member Name: _____ DOB: _____ MaineCare# _____

Provider Agency: _____ Agency Staff: _____

Provider Phone Number: _____ Fax Number: _____

Provider Email: _____

Request the following change for 65M&N assessment authorization:

Extended the last covered day (LCD) for the assessment: New LCD _____

Additional units in assessment; Clinician units: _____ BHP units: _____

Rationale for Request:

Fro DHHS/Clinical Advisor use only:

Clinical Advisor: _____

Clinical Advisor Recommendation:

- Approved
- Disapproved