

**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 1-800-400-8882 or the health insurer.

**1. Name of insured receiving the services** \_\_\_\_\_

**2. Address, phone number & e-mail of insured** \_\_\_\_\_

**3. Name of health insurer** \_\_\_\_\_

**4. Insured’s health insurance ID #** \_\_\_\_\_

**5. Name, address, phone number & e-mail 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) \_\_\_\_\_