CareConnect 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 CareConnect 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 us who should request preauthorization and if it can be done by telephone. CareConnect 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 your provider and to the insurer.
- For questions, contact the Department of Financial Services at 1-800-400-8882 or CareConnect.

1. Name of insured receiving the services

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

3. Name of health insurer
CareConnect Insurance Company, Inc.

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) _____