CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
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CareFirst Community Health Plan District of Columbia

ABARCA

Psychosocial Therapy Interventions

,V WKHUH D SODQ IRU SV\FKRVRFLDO LQWHUYHQWLRQ" *Supporting Clinical documentation may be attached*

If yes, please provide details of the plan:

If no, please explain why not:

Additional Information

3OHDVH SURYLGH UDWLRQDOH DQG PHGLFDO QHFHVVLWRE)KS LQSSWKH LQGLFDWLRQ *Supporting Clinical documentation may be attached*

By signing, this signature certifies that all the information provided on this request is complete and factual.

Physician Signature: _____ **Date Signed:** _____

7KLV SURJUDP LV IXQGHG LQ SDUW WKH \ WKH *LFYHUR &ROXPELD 'HSDUWPHQW RI

&DUH)LUVW %OXH&URVV +%OXH6KLHOG &RPPXQLW\RI &ROXPELD LV DQ LQGHSHQGHQW
6KLHOG $VVRFLDWLRQ %/8(&5266Š %/8(6+,(/'Š DQG WKH &URVV DQG 6KLHOG 6\PER
DQG %OXH 6KLHOG $VVRFLDWLRQ DQG DQW %OXH &URVV DQG %OXH 6KLHO

IMPORTANT: 7KLV IDFVLPLOH WUDQVPLVVLRQ PD\ FRQWDLQ LQIRUPDWLRQ RU FRS\LQJ RI WKLV LQIRUPDWLRQ
+HDQWKXUDQFH 3RUWDELOLW\ $FFRXQWDELOLW\ $FW +,3$$ 3ULYDF\ 5XOH &)5 3DUW
H[FOXVLYH XVH RI WKH LQGLYLGXDO RU HQWLW\ WR ZKRP LW LV DGGUHVVHG DQG PD\ FRQ
GLVFORVXUH XQGHU DSSOLFDEOH ODZ ,I \RX DUH QRW WKH LQWHQGHG UHFLSLHQW RU DQ
WKDW DQ\ GLVFORVXUH GLVVHPLQDWLRQ GLVWULEXWLRQ RU FRS\LQJ RI WKLV LQIRUPDWLRQ
VHQGHU E\ WHOHSKRQH DW DQJH WKH VHWXUQ RI RUPDWLRQ DQG DOO FRSLHV