Office on Mental Health

Core Service Agency of Harford County, Inc.

□ **Lab Work**
□ **Medications**

Please attach supporting documentation (lab referral, prescriptions)

125 N. Main Street/Rear **410.803.8726 Phone**

Bel Air, MD 21014 **410.803.8732 Fax**

LAB / MED REQUEST FORM

This form must be completely filled out before the request will be evaluated.
Please attach the Documentation for Uninsured Eligibility Benefit form.

Consumer's Name: _____ **SS#** _____ **DOB:** _____

Consumer's Address: _____ **Phone Number:** _____

Prescribing Physician: _____ **Phone Number:** _____ **Primary Diagnosis:** _____

Person making request: _____ **Requesting Date:** _____

Agency Name & Address: _____

Agency Telephone: _____ **Agency Fax:** _____

Psychotropic Medications:

Medication Name	Dosage	Cost

Describe Lab Work requested and how it is related to psychotropic meds: _____

_____

_____

_____

_____

_____

Eligibility & Vendor Information (Please fill out completely)

Is consumer eligible for Medical Assistance? (Circle one) YES/NO If yes, date applied? _____

Amount Requested: $_____ **Amount Client Can Pay: $**_____ **Amount from other resources: $** _____

Vendor/Pharmacy Name and Address: _____

Vendor/Pharmacy Telephone and Fax: _____

FOR OFFICE USE ONLY

Authorized: Yes ____ **No** ____ **Date:** _____ **Amount: $**_____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

OMH/CSA Authorization Code #: CSAHC_____ **Date Received:**_____