



Behavioral Health Treatment - Access to Care Form (Please fax the completed form to 714-954-2300)

Member Information

Last Name: _____ First Name: _____
CIN: _____ FBA Authorization #: _____

Appointment Information

1. FBA authorization start date (beginning date of approved FBA authorization): _____
2. Date of first offered FBA appointment: _____
3. Was the first FBA appointment offered within 10 business days of the FBA authorization start date? Yes No
4. If NO (appointment not offered within 10 business days), please provide reason: _____
5. Date of first scheduled FBA appointment: _____
6. Date of first attended appointment: _____
7. Was the first FBA appointment attended within 10 business days of the FBA authorization start date? Yes No
8. If NO (appointment not attended within 10 business days), please provide reason: _____

Signature (form completed by)

Print Name: _____ Title: _____

Signature: _____ Date: _____