Carelon Behavioral Health - Maryland

Attestation to Discharge Conflicting/Overlapping Authorization(s) Due to Non-Overlap Requirement

Participant Information

- Participant Full Name: _____
- Participant ID: _____
- Date of Birth: ____ / ____ / _____

Provider Information

- Provider Organization Name:

  SHARE WELLNESS CENTER

- Provider NPI / Provider Identifier: 1326960725
- Provider TIN Number: 39-3595844

Purpose

Certain services are not permitted to overlap according to COMAR 10.09.80.06B. You can also refer to the Combination of Mental Health Services document or the Combination of SUD Services document on Carelon's website for additional details.

This attestation documents the participant's (or Authorized Representative's) request to receive services with the provider listed above and to discharge/end any conflicting, overlapping authorization(s) that prevent authorization and/or delivery of those services.

If the participant has any questions, they can call customer service at 1-800-888-1965 to ask for additional details.

A) Participant / Authorized Representative Attestation

By signing below, I attest and agree that:

1. I am (check one):

   ☐ The participant identified above, OR

   ☐ The participant's Authorized Representative/legal guardian with legal authority to act on the participant's behalf.

2. I am requesting to receive the indicated behavioral health service(s) with the provider identified above.
3. I understand that certain service authorizations may not overlap, and that existing overlapping authorizations may prevent the requested services from being authorized and/or delivered from this Provider.
4. I am requesting that any conflicting and overlapping authorization(s) (including those associated with other provider(s)) that are not permitted to overlap with the services I am seeking with this provider be discharged/ended/closed, as allowed under program rules, so that services may proceed with this provider. I understand that conflicting and overlapping authorizations will be discharged/ended/closed immediately upon submission of this document.
5. I understand that ending/discharging an authorization may affect the participant's ability to receive services under the discharged authorization(s). I have had the opportunity to ask questions about this decision and have received answers I understand.
6. I attest that this decision is voluntary and made without coercion.

Printed Name (participant or Authorized Representative):

_____

If Authorized Representative, relationship to participant:

_____

If Authorized Representative, brief description of authority:

_____

Signature (wet signature only):

_____

Date Signed (MM/DD/YYYY): ___ / ___ / _____

B) Provider / Authorized Provider Representative Attestation

By signing below, I attest and agree that:

1. I am the provider or an Authorized Representative of the provider identified above, and I am authorized to sign this attestation on behalf of the Provider.
2. The participant (or Authorized Representative) completed this attestation in concert with the provider and affirmed they are seeking services with this Provider.
3. To the best of my knowledge, the participant may have an existing authorization(s) that conflicts with the non-overlap requirement for the service(s) being sought with this provider, and this attestation is intended to document the participant's request to discharge/end such conflicting, overlapping authorization(s) (including authorization(s) associated with other provider(s)).
4. I informed the participant (or Authorized Representative) that discharging an authorization may affect access to services under the discharged authorization(s) and provided an opportunity for questions.

Printed Name (Provider/Representative): _____

Title: _____

Signature (wet signature only): _____

Date Signed (MM/DD/YYYY): ___ / ___ / _____