Cornerstone Behavioral Healthcare
Medicare/Mainecare Waiver

DUAL ELIGIBLE MEMBER REQUEST: FOR LICENSED CLINICAL PROFESSIONAL COUNSELOR, LISCENSED MARRIAGE AND FAMILY THERAPIST, OR LICENSED MASTER OF SOCIAL WORK SERVICES.

Client Name: _____ Client ID#: _____

On June 28, 2013 you were notified of the following change to the MaineCare Benefits Manual Section 65 Behavioral Health Services. This change was effective August 1, 2013.

> Dual Eligible's (individuals who have both MaineCare and Medicare) will no longer be able to receive Behavioral Health Service from a Licensed Clinical Professional Counselors (LCPC's) or Licensed Marriage and Family Therapists (LMFT's). They must receive these services from a Licensed Clinical Social Worker (LCSW).
>
> If a dual eligible member lives farther than 30 minutes from an LCSW, they may be able to be seen by an LCPC or LMFT. They should call Member Services (1-800-977-6740) to find out if this is an option for them.

If you are having difficulty finding a Medicare participating provider and would like to receive services from a LCPC, LMFT, or LMFW, Please complete the following information for consideration of your case. Upon review, you will receive a written determination of approval or denial.

Name of Member requiring services:_____

Member MaineCare ID: _____

Member Address: _____

Are you currently in Therapy? Yes ⬭ No ⬭ If No, Skip to next question

If Yes, please provide the name and address of your current provider: _____

_____

Have you tried to find a Medicare participating LCSW or psychologist? Yes ⬭ No ⬭

If yes, who have you contacted for therapy services: (Complete below)

Contact 1:
Provider/Agency Name: _____
Date: _____ Contact Person: _____
Response: _____

Can they see client? ☐ Yes ☐ No

Contact 2:
Provider/Agency Name: _____
Date: _____ Contact Person: _____
Response: _____

Can they see client? ☐ Yes ☐ No

Please explain why you are unable to find a Medicare participating provider: _____

I have answered all questions truthfully and to the best of my knowledge. I authorize MaineCare to verify this information.

Completed by: _____ Date: _____