Individualized Service Recommendation (ISR)
PROS Admission Request

Fax or mail this form to: CDPHP Behavioral Health Services, 6 Wellness Way, Latham, NY 12110
Fax: (518) 641-3601

All fields must be completed and legible or the request cannot be processed. Approval of this form does not guarantee payment of benefits. Final determination is based on eligibility, authorization rules, and plan limits.

Date of Request: _____

Patient Information

Last Name: _____ First Name:_____
Member ID#: _____Date of Birth_____
Patient Signature: _____

Practitioner Information

Practitioner Name: _____Phone #:_____
Provider # or NPI: _____Fax # _____
Practitioner Signature: _____

Facility Information

Agency/Clinic: _____
Admission Date: _____
DSMV Diagnosis (please include both psychiatric and medical diagnoses):_____
_____
_____
_____

The following services will be provided during the development of the Individualized Recovery Plan Admission Date: (IRP); ISR is valid until the IRP is complete but no longer than 60 days from the Admission Date.				
Date Added	**Component (i.e. CRS, IR, ORS, Clinic Treatment)**	**Service Description/Modality**	**Expected Duration**	**Frequency**