



**Sexual Offense Risk Assessment Request Form**  
Fax to Magellan: 1.888.656.4916

- Please note that request must be made by the current treating practitioner.
- Requests for psychological testing (96101) for the JSOAP, ERASOR or JRAT will not be authorized separately but can be included in the H2000-SK.
- This service requires pre-authorization.

Today's Date: \_\_\_\_\_

Member Name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_

Member DOB: \_\_\_\_\_ Member's Legal Guardian: \_\_\_\_\_

Legal Guardian Contact Phone number: \_\_\_\_\_

**All of the following are required for approval. Please respond to each item:**

Is there a clinical recommendation for a Sexual Offense risk assessment from a licensed mental health professional?  Yes  No

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There is a current (within 30 days) psychiatric or psychological assessment with a DSM diagnosis?  Yes  No

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There is an age and/or development differential between the alleged perpetrator and victim?  Yes  No

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The behavior is assault and not better explained as poor judgment or experimentation?  Yes  No

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There is documented and credible evidence that a sexual assault occurred?

Yes  No

The member admits to the sexually aggressive behavior?

Yes  No

The member is willing to complete the evaluation?

Yes  No

The member is 18 years old or younger?

Yes  No

Name of Provider completing SO Risk Assessment: \_\_\_\_\_

Please indicate which CPT codes you are requesting: \_\_\_\_\_

Date of scheduled assessment: \_\_\_\_\_

Level of care client is currently participating in: \_\_\_\_\_

Requesting Practitioner Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_