Authorization Request Form

Behavioral Health Outpatient Treatment

Patient's Name: ____ DOB: __ /__ /__ ID#: ___________

***Please attach clinical information/progress notes, current medications, and therapeutic goals.**

Intensive in home therapy requires that a health check screening has been completed within the past 12 months. Intensive outpatient and Intensive in home levels of care require authorization prior to initiating services. Outpatient therapy does not require prior authorization until the initial six visits of the calendar year have been exhausted.

Diagnosis Code(s):

____

____

____

Patient Regularly Participates: ☐ Yes ☐ No

Date of First Visit: __ /__ /__

Number of Visits this calendar year: _________

Anticipated Discharge Date: _______________

Start Date: ________________________________

Type of Service: ☐ Mental Health ☐ AODA

☐ Individual Therapy	Frequency: __________	# Visits Requested: ____________
☐ Family Therapy	Frequency: __________	# Visits Requested: ____________
☐ Group Therapy	Frequency: __________	# Visits Requested: ____________
☐ Intensive	Hours/week: __________	*(4-12 hours/week)*
☐ Intensive In-Home	Hours/week: __________	*(4-8 hours/week)*

Brief Summary of Current Clinical Status:

Criteria for Termination:

Provider Name: ____

Facility Name: ____ NPI: ___________________

Address: ____ Tax ID: ___________________

Contact Name: ____ Phone: __________________ Fax: _________________

The submission of supporting clinical documentation/plan of care is required with this form.

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