Authorization Request Form

Behavioral Health Outpatient Treatment

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

***Please attach clinical information/progress notes, current medications, and therapeutic goals and fax all to (715) 852-5738.**

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.

Privacy and Confidentiality:
The information within this fax message is intended for the recipient(s) only. If you have received this fax in error, please contact us at 866-364-0892 and destroy this document received. State and Federal Law prohibits any unauthorized use of this information. Thank you for your cooperation.