



# 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 (608) 245-3097.**

*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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