Trilogy
Homegrown Health Care

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.