Trilogy
Homegrown Health Care

Authorization Request Form

Day Treatment/Partial Hospitalization

Patient's Name:_____DOB:__/__/__ID# _____

***Please attach clinical information including medications and fax all to (608) 245-3097.**

Diagnosis Code(s):

_____

_____

_____

Date of Admission __/__/__

Estimated Length of Stay: _____

☐ Mental Health ☐ AODA

Past Levels of Care Attempted:

Outpatient? If yes, when and where: _____

Inpatient? If yes, when and where: _____

Provider Name: _____

Facility Name:_____NPI: _____

Address:_____Tax ID: _____

Contact Name _____

Phone:_____ Fax: _____

Health Check screening documentation is required with this request. Members without a Health Check screening performed within the past 12 months will not be approved for this service. General follow up or problem focused appointments with a primary care provider do not qualify as a Health Check.

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