



Section 1 Member Information

Member Name: (Last, First, MI)	Date of Birth: / /	Member I.D:
Address: (No., Street, City, State, Zip)		Phone Number: ()
Sex:	Date submitted:	
Age:	Date of admission:	

Section 2 Facility Information

Facility Name: Contact Person:	Address:	Phone Number: ()	Fax Number: ()
TPI: NPI:	Is Member court ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Referral Source: <input type="checkbox"/> Admitting MD <input type="checkbox"/> MH Professional <input type="checkbox"/> Other (list):			

Section 3 Treatment Goals

Client is meeting treatment goals: Yes No

The client demonstrates an insight and understanding into relationship with mood altering chemicals, but continues to present with issues addressing the life functions of work, social, or primary relationship without the use of mood-altering chemicals: Yes No

Client is physically abstinent from chemical substance use but remains mentally preoccupied with such use to the extent that the client is unable to adequately address primary relationships, or social or work tasks, but there are indications that, with continued treatment, the client will effectively address these issues: Yes No

Section 4 Additional Clinical Information

Psychiatric or medical complications that affect the client's treatment, but the client continues to show treatment progress and there is evidence to support the benefits of continued treatment.

(Required only if 'No' is checked to any questions in section 3)

Section 5 Medication

Current medication with total daily doses (Required only if 'No' is checked to any question in 3)

Section 6 DSM-IV Diagnostic Codes/Service Request

Axis I (Include all):	Axis II:
Axis III:	Axis IV: Axis V GAF:

Section 7 Behavioral Health Authorization

Authorization #:	Number of additional outpatient hours requested Individual: Group:
Approved Duration:	

Section 8 Attending Provider Information

Signature (attending MD):	Date: / /
Print Name:	Provider License Number:

This is not a guarantee of benefits, only a review of the requested services for appropriateness and necessity. Reimbursement is based on the benefits available at the time of the service.

Signature: _____ Title: _____

*Please attach additional information, if necessary.