

PANEL PROVIDER AUTHORIZATION REQUEST FORM

INSTRUCTIONS TO PANEL PROVIDERS: PLEASE COMPLETE BOXES 1 THROUGH 17 AND SUBMIT FORM TO THE COUNTY FOR PROCESSING. IF THIS IS A REQUEST TO EXTEND OR CHANGE A CURRENT AUTHORIZATION, REQUEST SHOULD BE SUBMITTED PRIOR TO LAST AUTHORIZED SERVICE.

INSTRUCTION TO COUNTY UM: PLEASE COMPLETE SHADED AREA IN BOXES 18 THROUGH 22 AND RETURN ONE COPY TO PANEL PROVIDER. IF APPROVED, ENTER AUTHORIZATION IN PHTECH'S SYSTEM (CIM).

1) Client Name		2) DOB	3) OMAP ID#
4) Provider Name		5) Date of request	6) Date of first service
7) Multi-axis diagnoses at start of service <u>Number Name</u> I II III IV. V. (GAF/CGAS)		8) Current Diagnoses (if changed) <u>Number Name</u> I II III IV. V. (GAF/CGAS)	
9) Clinical Formulation: your clinical judgment regarding how continuing treatment will address the member's presenting problems and goals, e.g. family therapy will focus on communication issues that are driving teenager's anxiety and acting out.			
10) Treatment Goals 1. 2. 3.		11) Discharge Criteria 1. 2. 3.	
12) Progress To Date (reference goals above) 1. 2. 3.			
13) If this member is involved with more than one provider, describe coordination of care:			
14) Date Range Request: From: ___/___/___ To ___/___/___			
15) Service Authorization Requested (please check the box next to the service requested)		16) Number of Sessions Requested	17) Comments
<input type="checkbox"/> Diagnostic Intake / Evaluation / Assessment			
<input type="checkbox"/> Individual Psychotherapy			
<input type="checkbox"/> Family Psychotherapy			
<input type="checkbox"/> Group Psychotherapy			
<input type="checkbox"/> Medication Management			
<input type="checkbox"/> Case Management			
<input type="checkbox"/> Other: (Define)			
18) Request <input type="checkbox"/> Authorized; <input type="checkbox"/> Denied (Check one) By (UM signature):		19) Authorization Number (From CIM)	
20) Co. UM Printed Name:		21) Date	
22) Additional information needed (if required):			