Montana Mental Health Services Plan

Adult Intensive Outpatient Services

Continued Stay Authorization Request Form

To transmit request information:	Or Mail To: AMDD Benefit Management Team
	PO Box 202905
FAX: 1-406-444-7391 Attn: Linda Nelson	Helena MT 59620

PLEASE PRINT OR TYPE

	Units Requested	
H0046 HB		**Individual or family therapy sessions => 90 units max.**
H2014		**1:1 DBT coaching & case management => 90 15-min. units max.**
H2014 HQ		**DBT skills group sessions => 260 15-min. units max.**

CLIENT INFORMATION

Client Name:	**MHSP Number:**
DOB: / /	**Gender: M F**

PROVIDER INFORMATION

Primary Therapist's Name:	**NPI Number:**
Telephone Number:	**Fax Number:**
MHC Name:	**NPI Number:**
City:	**Zip Code:**

CLINICAL INFORMATION

Has the DSM Diagnosis Changed since last request? **NO ☐ YES ☐ If yes, list below**

Axis I	**Code**	**Narrative**
	Code	**Narrative**
Axis II	**Code**	**Narrative**

Check any services utilized by this individual within the past 90 days:

Acute Psychiatric Hospital	☐	**Adult Day Treatment**	☐
State Hospital (MT or other)	☐	**Adult Group or Foster Home**	☐
Crisis Stabilization	☐	**Medication Management**	☐
Emergency Room	☐	**Crisis Line**	☐
Chemical Dependency Treatment	☐	**Other:**	☐

Medication Changes, if any:

Current Psychological Symptoms, Behavior, and Level of Functioning:

Processing may be delayed if information submitted is <u>illegible</u> or <u>incomplete</u>

Revision 02/09

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Changes to Treatment &/or Crisis Plan:
Brief summary of client's progress in Intensive Outpatient Treatment:

I certify that I have reviewed the Clinical Management Guidelines for Intensive Outpatient Therapy Services as and that this client meets these guidelines at this time.

Assessment completed by (please type or print):
Signature: **Date:**

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