Mental Health Services Plan

Adult Intensive Outpatient Services

Initial Prior Authorization Request Form

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

PLEASE PRINT OR TYPE

	Units Requested	Start date:
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-minute 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:**

DSM-IV DIAGNOSIS (including co-occurring disorders)

Axis I	**Code**	**Narrative**
	Code	**Narrative**
	Code	**Narrative**
Axis II	**Code**	**Narrative**
	Code	**Narrative**
Axis III		
Axis IV		**Axis V**

TREATMENT HISTORY & CONCURRENT SERVICES

Acute Psychiatric Hospital	**Past ☐**	**Present ☐**
State Hospital (MT or other)	**Past ☐**	**Present ☐**
Crisis Stabilization	**Past ☐**	**Present ☐**
Chemical Dependency Treatment	**Past ☐**	**Present ☐**
Adult Day Treatment	**Past ☐**	**Present ☐**
Adult Group Home / Foster Care	**Past ☐**	**Present ☐**
Emergency Room	**Past ☐**	**Present ☐**
Crisis Line	**Past ☐**	**Present ☐**
Case Management	**Past ☐**	**======➔ TO BE BILLED AS H2014 – SEE ABOVE**

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

Revision 02/09

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Current Medications:
Current Psychological Symptoms, Behavior, and Level of Functioning:
Treatment Plan:
Crisis Plan:

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 print or type):	
Signature:	**Date:**

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