



## Outpatient Treatment Authorization Form

**Provider Information:**

Name  
Address  
Phone Number

**Subscriber Information:**

Name:  
Address:  
City, State, Zip:  
  
Contact Phone:

**Patient Information**

Name:  
Sex  
DOB:  
MBR-ID:

**Plan Information:**

Plan Name:  
ID#

**Authorization Information:**

Auth #:  
Code:  
Total Sessions Authorized Thru Dec 31 20\_\_\_\_:  
Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**\*\*NOTE:** The number of sessions noted above is the *total* number of sessions that have been authorized from the start date of the initial authorization. It includes, but is *not limited to*, additional sessions approved since the start date of the last authorization.

### Request For Re-Authorization Form

If additional sessions are required, please complete the requested information below and either mail or fax the request to APS. The form should be submitted with complete information before the existing sessions have been used or will expire. Completed forms will be reviewed and a decision made within ten business days (unless state laws indicate otherwise) of receipt of all necessary clinical information

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Diagnosis Axis I: Primary Dx Code \_\_\_\_\_ Dx Code \_\_\_\_\_ Dx Code \_\_\_\_\_  
Axis II: Dx Code \_\_\_\_\_  
Axis III: \_\_\_\_\_  
Axis IV: \_\_\_\_\_  
Axis V (GAF Score): At first session \_\_\_\_\_, Current \_\_\_\_\_, Highest in the past year \_\_\_\_\_

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**Disclaimer: Authorization of care is based on eligibility and benefits at the time services are rendered.**  
**This authorization is not a guarantee of payment.**  
**Claims are verified to ensure that pre-authorization approval and claims information is consistent, that the patient is eligible for services at the time of treatment, that all services are covered by the Health Plan, and that all benefit requirements have been satisfied, including co-pays, deductibles, and limits, such as pre-existing conditions.**

**\*\*PLEASE NOTE THAT 2<sup>ND</sup> PAGE IS REQUIRED**

\_\_\_\_\_ (Y/N/NA) If you are the treating therapist and your patient suffers from Bipolar Disorder, Schizophrenia or another Psychotic Disorder or moderate to severe Major Depression, has the patient been referred to a psychiatrist for medical evaluation?

\_\_\_\_\_ (Y/N/NA) If you are the treating therapist and your patient suffers from Bipolar Disorder, Schizophrenia or another Psychotic Disorder or moderate to severe Major Depression, is the patient currently seeing a psychiatrist for ongoing medical monitoring?

\_\_\_\_\_ (Y/N/NA) If you are the treating therapist and your patient is under the age of 18, was a family assessment completed within 30 days of the initial evaluation? Please note that a family assessment could include any session where the patient was seen with a parent, foster parent, or guardian.

\_\_\_\_\_ (Y/N/NA) If you are the treating therapist and your patient is under the age of 18, is ongoing family therapy occurring as part of treatment?

CPT Code: \_\_\_\_\_ Number of Units: \_\_\_\_\_

Frequency of sessions (once a week, etc): \_\_\_\_\_

Requested start date of authorization: \_\_\_\_\_

CPT Code: \_\_\_\_\_ Number of Units: \_\_\_\_\_

Frequency of sessions (once a week, etc): \_\_\_\_\_

Requested start date of authorization: \_\_\_\_\_

I attest that to the best of my knowledge, the above information is accurate.

\_\_\_\_\_  
Signature

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