



*Treating people right*

## Treatment Authorization Request

Patient's Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Health Plan: \_\_\_\_\_

Provider: \_\_\_\_\_ Telephone No: \_\_\_\_\_

### Type of Treatment Requested:

- Individual Therapy
- Psychiatric/Medical Evaluation
- Medical Management
- Inpatient Psychiatric Treatment
- Inpatient Substance Abuse Treatment
- Partial Hospitalization
- Residential Treatment
- Intensive Outpatient Treatment
- Other; specify: \_\_\_\_\_  
\_\_\_\_\_

Number of Sessions: \_\_\_\_\_

Frequency: \_\_\_\_\_

Number of Days: \_\_\_\_\_

Schedule: \_\_\_\_\_

Additional Recommendations/Referrals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treatment Goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date Treatment Is To Be Completed:** \_\_\_\_\_

**PROVIDER'S NAME:** \_\_\_\_\_