The Holman Group
Managed Behavioral Health Care Services

Request for Treatment Authorization
(for follow-up visits only)

Patient: _____ Date of Birth: _____

Insured's Name: _____ Patient's Phone #: _____

Provider/ Facility: _____ Provider/ Facility Phone#: _____

List all dates of service utilized during & beyond the most recent authorization (specific dates):

This is a request for: ☐Individual – 90834 (45 min.) ☐Individual – 90837 (60 min.) ☐Conjoint Tx ☐Marital

Medication Mgt.: ☐EM99213 ☐EM9921 ☐90833 (20-30 min.) ☐90836 (45-50 min.)
☐Other: _____

Dates Requesting: Times Per Week: _____ Month: _____ Other: _____

ICD-10: _____

Symptoms/ functional impairment that meet medical necessity for further treatment:

List current medications, dosage level & prescribing physician:

Drug & Alcohol current use history: ☐None ☐Use ☐Dependence ☐Abuse ☐12 Step _____
☐Inpatient Treatment ☐Outpatient Treatment

Substance(s)	Quality	Frequency	Date of Last Use	Duration of Use	Number of Attempts at Recovery	Type CD Treatment

Received informed consent for medication: ☐Yes ☐No ☐N/A Any Allergies? ☐Yes ☐No

Progress Made:

Updated treatment plan, including specific goals/plan for resolving symptoms:

Additional Referrals (e.g. Medication Evaluation, Alcoholics Anonymous, etc.):

Type	Date Referred	Date Attended	Patient Unwilling
			☐Yes ☐No ☐N/A

Expected date of treatment termination: _____

I have coordinated care with other treating providers: ☐Yes ☐No ☐N/A

To request referrals under the patient's mental health benefits, please call The Holman Group at (800)321-2843

☐I certify that the above is true and correct. The treatment plan has been reviewed and agreed upon by the patient.

Provider's Name: _____ **Date:** _____

Provider's Signature: