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 Tx ☐ Group Tx ☐ Conjoint Tx ☐ Marital ☐ Other: _____

Medication Mgt.: ☐ EM99213/EM99214 ☐ EM+90833 (20-30 min) ☐ EM+90836 (45-50 min) ☐ Other: _____

Dates Requesting: From: _____ To: _____

Treatment Frequency: 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 ☐ Inpatient Treatment _____ ☐ Outpatient Treatment _____ ☐ 12 Step _____

Substance(s)	Quantity	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

To request referrals under the patient's mental health benefits please call (800) 321-2843.

Expected date of treatment termination: _____

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

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

Provider's Signature: _____ Date: _____