

OUTPATIENT MENTAL HEALTH & CHEMICAL DEPENDENCY
Treatment plan summary and authorization form

For Assistance, please contact us at: Phone (952) 896-1211 or (800) 444-5769 Fax (952) 896-1261

Patient _____ DOB _____ GENDER _____

Policy Holder _____ ID# _____

Therapist/MD _____ Telephone# _____

Clinic/Hospital _____

Address _____
(Street) (City) (State) (Zip)

Tax ID number _____

Axis I Code _____ Axis II Code _____

Axis III Code _____

Axis IV Code _____

Axis V GAF _____ Initial _____ Current _____

Other Providers _____

Current Medication _____

Brief History _____

Symptoms/Problems _____

Measurable Behavioral Goals and Objectives _____

Interventions _____

Progress To Date _____

Resolution To Date _____

Discharge Criteria _____

Start of Care Date: _____ #of Sessions To Date _____ Frequency/Duration: _____

Visits requested _____

CPT Code: 90801#__ 90804#__ 90805#__ 90806#__ 90847#__ 90853#__ 90862#__ 90870#__ other#__

of visits per SPD _____ Previous auths _____

Approved _____ # Denied _____

Provider's Signature _____ Date _____