



## Authorization Request for Additional Inpatient Mental Health Services

This request is to only be used for ADDITIONAL INPATIENT MENTAL HEALTH SERVICES for a client. To request new inpatient services, please complete the "Authorization Request for New Inpatient Services" form found at [www.team-mn.com](http://www.team-mn.com). Please print clearly. Incomplete or illegible forms can not be processed.

### Client Information

Client's Name

Client's Date of Birth

Group #

ID #

Expected Length of Stay

Current Diagnoses
Axis I:
Axis II:
Axis III:
Axis IV:
Current GAF:

Current Psychotropic Meds & Dosage

Updated Clinical Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Provider Information

Name of Hospital/Clinic/Organization

Attending Doctor

Hospital/Clinic/Organization Address

Name of Requestor

Requestor's Phone #

Requestor's Fax #

Additional Comments:

Please fax completed forms to T.E.A.M. at (651) 642-1809