



Authorization Request for Additional Outpatient Mental Health Service

This request is to only be used for **ADDITIONAL OUTPATIENT SERVICES** for a client. Requests for new outpatient services should be directed to TEAM using the “Authorization Request for New Outpatient Services” at www.team-mn.com.

Client's Name	Provider Name
Client DOB	Degree & License Type
Policy Holder's Name	Clinic Name & Location
Group #	Provider Phone #
ID#	Provider Fax #

Diagnosis
GAF

Measurable Objective	Method for Achieving Objective	Progress *	Resolution Date

*Progress Rating Scale: N-New Objective 1-Decreased 2-Improvement 3-Resolved

Suicidality: None Ideation Plan Intent Ideation in Past Year Attempt in the Past Year

Homicidality: None Ideation Plan Intent Ideation in Past Year

Substance History (indicate drug/s of choice): _____ Abuse Dependence

Current Frequency of Visits: _____

Services Requested (Include # of sessions needed; not to exceed 10): 90804: _____ 90805: _____
 90806: _____ 90847: _____ 90853: _____ 90862: _____ Other: _____

Psychotropic Medications and Dosage: _____

Clinician's Signature
Date

Please fax completed forms to TEAM at (651) 642-1809