



Authorization Request for Day Treatment or Partial Hospital Program

This request is to be used for **NEW AND CONTINUING SERVICES** for a client. Treatment plan *must* accompany this request. *Please print clearly. Incomplete or illegible forms can not be processed.*

Client Information

Client's Name

Client's Date of Birth

Name of City In Which Client Lives

Client's Phone #

Group #

ID #

Policy Holder's Name

Presenting Issue/Diagnosis

Provider Information

Type of Program (CD, MH, MI/CD)

Expected Length of Program

Clinical Hours Per Day Spent With Licensed Provider

Total Hours Per Day Spent in Program

Name and Address of Organization

Name of Requestor

Requestor's Phone #

Requestor's Fax #

IMPORTANT: Treatment plan *must* accompany request in order to authorize treatment.

Additional Comments:

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