



Authorization Request for New Inpatient Mental Health Services

This request is to only be used for NEW INPATIENT MENTAL HEALTH SERVICES for a client. To request additional inpatient services, please complete the "Authorization Request for Additional Inpatient Services" form found at 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

Name of City Client Lives In

Client's Phone #

Group #

ID #

Policy Holder's Name

Admission Diagnoses

Axis I:

Axis II:

Axis III:

Axis IV:

Current GAF:

Admission Date

List All Psychotropic Medications & Dosage

Client Presented to Hospital:

- On Own
- By Police/Ambulance
- Transferred from Another Hospital
- With Family/Friend

Client is:

- Voluntary
- On 72 Hour Hold

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