



## Authorization Request for New Outpatient Mental Health Service

This request is to only be used for NEW SERVICES for a client. Requests for additional services should be directed to TEAM using the "Authorization Request for Continued Sessions" 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
_____	_____
Name of City Client Lives In	Client's Phone #
_____	_____
Group #	ID #
_____	_____
Policy Holder's Name	Client's Presenting Issue

### Provider Information

_____	
Services Requested (include CPT/Service Codes)	
_____	_____
Name of Clinic/Organization	Clinician Name & Credentials
_____	
Clinic Address	
_____	_____
Name of Requestor	Requestor's Phone #
_____	
Requestor's Fax #	

**IMPORTANT: Authorizations are usually completed within 1-3 business days.**

Additional Comments:

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