Date of Form Submission:

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 notbe processed.***

Client Information

Client's Name	**Client's Date of Birth**
Client's Address	**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 Email Address & Fax #	**Requested Start Date of Service**

Additional Comments:

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

Submit completed forms via email or fax to TEAM

TEAM Corporation
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