



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.

Client Information

Client's Name

Client's Date of Birth

Client's Address

Client's Phone #

Group #

ID #

Policy Holder's Name

Admission Diagnoses:

Admission Date

List All Psychotropic Medication(s) & Dosage(s)

Client Presented to Hospital:

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

Client is:

- Voluntary
- On 72 Hour Hold
- Suicidal
- Homicidal
- Delusional
- Hallucinating

Provider Information

Name of Hospital/Clinic/Organization

Attending Doctor

Hospital/Clinic/Organization Address

Name of Requestor

Requestor's Phone #

Requestor's Email Address & Fax #

Additional Comments:

Submit completed forms via email or fax to TEAM