Date of Form Submission:

Notification Review 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 "Notification Review for Continued Sessions" 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**

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

Additional Comments:

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

Submit completed forms via email or fax to TEAM

TEAM Corporation
Roseville Office Plaza, 1970 Oakcrest Avenue - Suite 200, Roseville, MN 55113
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Main: 651.642.0182 | Duluth: 218.727.8589 | Toll Free: 800.634.7710 | Fax: 651.642.1809