



MD/NP Managed Care Assessment - Authorization Request

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

DIRECTIONS – Submit after initial authorization for assessment or if on-going treatment is being requested, prior to expiration of initial authorization. Incomplete information may result in delay of authorization for services. **Please complete all information requested on this form. Any services provided without prior authorization will be denied.**

PROVIDER (Print) _____ Phone _____ Fax _____

CLIENT NAME _____ DOB _____ Date _____

Current Clinical Issues

Substance Abuse Current Past None Describe type, amount, frequency
(incl Nicotine, Caffeine, and OTC)

History, Relevant Clinical or Other Information (Include present &/or previous physical
&/or sexual abuse – victim &/or perpetrator)

Medications (for Medical and Psychiatric Conditions)

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Diagnosis Use "P" and "S" to specify one **Primary** and one **Secondary** Mental Health Diagnosis. You may report up to three additional diagnoses. Do not enter the Code for a "Rule Out" Diagnosis.

DSM5 Diagnosis	ICD-10	P/S	DSM5 Diagnosis	ICD-10	P/S

General Medical Conditions:

Other Factors Significantly Affecting Mental Health				
Substance Abuse	Yes	No	Unknown	
Developmental Disabilities	Yes	No	Unknown	
Physical Health Disorders	Yes	No	Unknown	

Treatment Goals

1) _____ Target Date _____

2) _____ Target Date _____

These goals have been formulated in conference with, and have the approval of, the Mental Health Plan member/parent or guardian.

Provider Signature _____ Date _____

Client/Parent _____ Date _____

TREATMENT AUTHORIZATION REQUEST

CPT Code	Bilingual Differential Yes/No	Number of Services	Frequency	Authorization Begin Date