hor_307 WOODLAND HILLS SERVICE AREA

After 1st 10 sessions: Fax form to#: **888-896-4727**

**After *2nd & subsequent*: Email to WH-OUTSIDEMEDICALCASE-MANAGEMENT@KP.ORG**

**\*\*FORM IS DUE 7 DAYS PRIOR TO EXPIRATION OF CURRENT AUTHORIZATON\*\***

**\*\*Incomplete forms will be returned \*\* No retroactive authorization will be issued\*\***

Date:

**Clinical Documentation**

REQUEST FOR REAUTHORIZATION – or Discharge Summary

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Provider name: | | | | Patient name: | | | Patient MRN: |
| Diagnosis (full descriptive term): | | | | Icd10: | | | Patient DOB: |
| Authorization #: | | Reason for reauth. request:  Time period expired (6 months)  # of visits expired | | | | | CPT Code(s) |
| Recommend Continued Treatment | | | Recommend Discharge | | | | Total # of sessions for this patient since **beginning** of treatment with you: |
| Dates of service for current auth #: | | | | | | | |
| Session # 1: |  | | | | Session # 2: |  | |
| Session # 3: |  | | | | Session # 4: |  | |
| Session # 5: |  | | | | Session # 6: |  | |
| Session # 7: |  | | | | Session # 8: |  | |
| Session # 9: |  | | | | Session #10: |  | |

**Progress Summary**

1. Focus of Clinical Attention for this 10 session episode of care:

1. Describe measurable clinical/behavioral progress for session completed; what evidence do you and the patient observe?

1. Patient participation in treatment:

Participates Actively

Moderately Invested

Poor Compliance

Other: Explain:

**Current Status**

1. Observed and reported **clinical symptoms** (reference DSM V) in last 2 weeks (specify acuity level of symptoms e.g, mild, moderate, severe). List should support diagnosis with specifiers.

1. Describe level of **functioning in every day life** (including but not limited to activities of daily living: grooming, hygiene, eating, sleeping; ability to manage various roles: family, friend, employee, community member; ability to work or function in school; etc). Compare to baseline functioning.

1. With continued treatment, how likely is it that the presenting mental health condition will improve? Why or why not?

1. Describe and clarify **risk factors** if any (include and explain harm to self, harm to others, risk for decompensation or regression):

**Treatment Plan- Create with patient**

1. 2-3 agreed upon SMART goal(s) going forward:

*Specific, Measurable, Attainable, Realistic, Time-Limited*

1. Action items to move toward goal(s):

*What specific action does patient need to take in order to progress?*

**Clinical Recommendations** for adjunct services (medication evaluation, group therapy or workshop assessement, higher level of care assessment) – please be specific:

Provider Name and License:

Provider Email and Phone:

Date: