hor_307 WOODLAND HILLS SERVICE AREA

REQUEST FOR REAUTHORIZATION – *1st renewal ONLY*

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

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

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

|  |  |  |
| --- | --- | --- |
| Provider name: | Patient name: | Patient MRN: |
| Diagnosis (full descriptive term): | Icd10: | Patient DOB: |
| Authorization #: | Recommend Continued Treatment  Recommend Discharge | |
| Total # of sessions of ***this episode of care***     Was there a previous episode?     As needed, explain below. | | |
| Dates of service for current auth #, please list: | | |

**Outside Referral Dept update:**

1. Yes  No: Primary coverage is Medi-Cal
2. Yes  No: Diagnosis has been changed and needs to be updated in HealthConnect
3. Yes  No: This is first renewal after 10 sessions or 6 months, whichever came first.

**Treatment Summary and Clinical Indication for additional treatment**

1. Patient participation in treatment:

Participates Actively Poor Compliance

Moderately Invested Other: Explain:

1. Yes  No

Observed and reported **clinical symptoms** (reference DSM V) in last 2 weeks support the diagnosis/es noted above.

Comments:

1. Yes  No

**Compared to this patient’s baseline, functioning in every day life** is compromised. (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)

Comments:

1. Yes  No  N/A

It is likely that the presenting mental health condition *will improve* with continued treatment. **OR**

Yes  No  N/A

It is likely that the presenting mental health condition *will significantly deteriorate* without continued individual psychotherapy.

Comments:

\*Note that patients with risk factors or needing additional services must be reviewed directly with an OSM Clinical Liaison: contact information available on “Quick Reference” provided by Behavioral Health.

Provider Name and License:

Provider Email and Phone:

Date: