**KP Panorama City**

**Email form to:** [**External-Referral-Team-STR@KP.ORG**](mailto:External-Referral-Team-STR@KP.ORG) **or Fax to: 818-758-1361**

**Clinical Documentation**

REQUEST FOR REAUTHORIZATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider name:** | | **Patient name:** | | | **Patient MRN:** |
| **Diagnosis (full descriptive term):** | | **ICD 10:** | | | **Reason for reauth. request:**  Time period expired (6 months)  # of visits expired |
| Recommend Continued Treatment | |  | | | Total # of sessions for this patient since beginning of treatment with you: |
| **Dates of service for current auth #:** | | | | | |
| Intake Date: |  | | Session # 7: |  | |
| Session # 1: |  | | Session # 8: |  | |
| Session # 2: |  | | Session # 9: |  | |
| Session # 3: |  | | Session # 10: |  | |
| Session # 4: |  | | Session #11: |  | |
| Session #5: |  | | Session #12: |  | |
| Session #6: |  | |  |  | |

**Presenting problems, symptoms/functional impairment (s):**

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

**Treatment goal (s):**

1.

2.

**Describe measurable clinical/behavioral progress towards treatment goals:**

**Patient participation in treatment:**

Participates Actively

Moderately Invested

Poor Compliance

Other: Explain:

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

|  |  |  |
| --- | --- | --- |
| **Provider Signature:** | |  |
| **Date:** |  | |