OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:

Provider Number:

Date Completed:

(R-04-03-09)

Recipient ID #:_____ **Provider #:**_____

SERVICES REQUESTED
(pick only one)

☐ **PG001 – Prevention & Recovery Maintenance**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG002 – Level 1 OP ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG003 – Level 2 OP (includes 0-36 mo)**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG004 – Level 3 OP ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG008 – Level 4 OP ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG015 – Level 4 OP Intensive In home - Child Systems of Care Only**
____ # of MONTHS REQUESTED (1-6 months)

☐ **PG019 – ICF/MR ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG031 – RBMS ____ # of MONTHS REQUESTED (1-6 months)**

☐ **PG025 – Exceptional Case – one month only**

SUBMIT THIS FORM ALONG WITH THE
OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION FORM