OUTPATIENT REQUEST FOR PRIOR AUTHORIZATION

Client Name:		
Provider Number:		
Date Completed:		Page 1 of 1
		(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 (i	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 I	ntensive 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