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# Continued Outpatient Treatment Request Form for Out of Network Providers and Required Prior Authorization Services

**coOportunityHealth CANNOT accept a completed form via e-mail. Can only accept via fax 952-853-8830 or US mail.**

| **Name of Member to Receive Services:** | **Member's Insurance ID #:** | **Member's DOB:** |
|---|---|---|

| **Provider Name / Degree/ License** | **Phone #** | **Fax #** |
|---|---|---|
| **Address:** | **Tax ID #** | **NPI #** |
| **Is provider Supervised? _____ Yes _____ No** | **Supervisor / Degree/ License** | |

**Note: Use the In-home Therapy Request Form for all first time authorization requests for in-home therapy**

**Is this care being provided in the home? _____ Yes _____ No**

**If yes, why does care need to continue in the home and not in the office?**

**If yes, when will the member be ready to transition care to the office?**

**# of each CPT or HCPC code requested: 90834: 90837: 90846: 90847: 90853: Others:**

**Authorization Dates Requested: Start Date: End Date:**

**Current and Provisional DSM (most recent edition) Diagnosis(es) (Axis III) diagnosis(es) with code(s).**
**Axis I: Axis II: Axis III: Axis IV: Axis V:**

**PROGRESS ON SYMPTOMS SINCE LAST AUTHORIZATION/Current symptoms for each diagnosis with frequency/intensity**
(E.g. Difficulty sleeping – was averaging 4-5 hrs 7/7 nights and is now sleeping 6 hrs a night 4/7 nights x 2 wks)

**PROGRESS ON TREATMENT GOALS SINCE LAST AUTHORIZATION/Current measurable goals with how measured:**
(E.g. Goal 1: Decrease depr as reflected by a Beck Depr Inventory score of 10 or less. Last review was a 19 and now is at a 13 x 2 wks )

**How will you know that the member is ready to terminate treatment?** (E.g. BDI of 10 or less for 3 months)

**Medication changes and dates:**

**Estimated termination date:**

| **Form completed by:** | Date: | Phone #: |
| --- | --- | --- |