

**Required Clinical for Authorization of Clients
Placed From Designated Counties**

Fax Line: 855-524-6067

Please complete this form and fax to the above number
(PLEASE PRINT LEGIBLY)

Member: _____ Member ID: _____ DOB: ____/____/____

Provider: _____ Ph: (____) _____ Fx: (____) _____

A) Axis I diagnosis: _____

B) Current Impairments:

[0 – none, 1 –Mildly Incapacitating, 2 – Moderately Incapacitating, 3 – Severely Incapacitated, NA – Not Assessed]

Member Risk to Self

0 1 2 3 NA

Member Risk to Others

0 1 2 3 NA

Mood Disturbance (Depression or Mania)

0 1 2 3 NA

Weight Loss Associated w/ an eating disorder

0 1 2 3 NA

Anxiety

0 1 2 3 NA

Medical/Physical Conditions

0 1 2 3 NA

Psychosis/Hallucinations/Delusions

0 1 2 3 NA

Substance Abuse/Dependence

0 1 2 3 NA

**Thinking/Cognition/Memory/Concentration
problems**

0 1 2 3 NA

Job/School Performance Problems

0 1 2 3 NA

Impulsive/Reckless/Aggressive Behavior

0 1 2 3 NA

Social Functioning/Relationships/Family problems

0 1 2 3 NA

Activities of Daily Living problems

0 1 2 3 NA

Legal Problems

0 1 2 3 NA

C) Treatment Plan: Please ensure proposed interventions are in behavioral/emotional terms that a) address the above identified condition, is expected to b) significantly diminish the impairment, c) prevent significant deterioration in an important area of life functioning or d) allow the child to progress developmentally as individually appropriate.

For Internal Use Only: Auth Number: ____-____-____-____
Type: _____ # of Sessions: ____ Eff Date: ____/____/____ Exp Date: ____/____/____ CM/CSR: _____
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