The Holman Group
Managed Behavioral Health Care Services

Request for Treatment Authorization
(For Follow-Up Visits Only)

PATIENT/ INSURER'S INFORMATION			
Patient Name:		**Insured:**	
Date of Birth:		**Insured ID:**	
Age:		**Employer/ Union:**	
Patient Ph#:		**Relationship:**	
PROVIDER/ FACILITY INFORMATION			
Provider/ Facility:		**Phone#:**	
Address:			

AUTHORIZATION REQUEST INFORMATION				
Type of Treatment Requested/ Medication Mgt.				
☐Individual Tx ☐Group Tx. ☐Conjoint Tx. ☐Marital ☐ Other:				
CPT Code(s) Requested:				
Date(s) Requesting:	From:		To:	
Frequency:	☐Weekly ☐Monthly ☐Annually ☐ Other:			
ICD-10:				
Symptoms/ functional impairment that meet medical necessity for further treatment:				
List of current medications, dosage level, & prescribing physician:				
Received informed consent for medication:	☐Yes ☐No ☐N/A		**Any Allergies?**	☐Yes ☐No
List all dates of service utilized during and beyond the current authorization period (specific dates):				

Drug & Alcohol Current Use and History

☐None ☐Use ☐Dependence ☐Inpatient Treatment ☐Outpatient Treatment ☐12 Step

Substance(s)	Quantity	Frequency	Date of Last Use	Duration of Use	# of Attempts at Sobriety	Type CD Treatment

Progress Made

TREATMENT PLAN

Current Symptom(s)	Intervention	Target Date	Estimated Termination Date
1.	1.		
2.	2.		
3.	3.		
4.	4.		

Updated treatment plan, including specific goals/ plan for resolving symptoms:

Use of adjunctive therapies: ***(outpatient therapy, self-help programs, etc. (e.g. Alcoholics Anonymous)***

ADDITIONAL/ RECOMMENDED REFERRALS

(To Request referrals under the patient's mental health benefits please call The Holman Group at 800-321-2843)

Type	Date Referred	Date Attended	Patient Waiting

If applicable, I have coordinated care with other treating providers: ☐Yes ☐No ☐N/A

PROVIDER/ FACILITY SIGNATORY

I certify that the above information is true and correct, and the treatment plan has been reviewed and agreed upon by the patient.

Provider Name/ Title (Print)	**Signature**	**Date**