



**Request for Continued Outpatient Authorization of Services v041008**

Please complete all applicable sections of this form legibly and fax to PsychHealth, Ltd. at (847) 864-9930. If you need assistance, please contact PsychHealth Ltd. Clinical Care Department at (847) 864-4961.

Member's First and Last Name: \_\_\_\_\_ Member Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Member's Medical Group/IPA/Health Plan: \_\_\_\_\_ Member Insurance ID #: \_\_\_\_\_

Requesting Provider's Name and Credentials: \_\_\_\_\_ PsychHealth, Ltd. Provider ID number \_\_\_\_\_  
Requesting Provider's Telephone # \_\_\_\_\_ Previous PsychHealth, Ltd. Referral number \_\_\_\_\_

Behavioral healthcare providers must document coordination of care with the member's Primary Care Physician.

Member's Primary Care Physician (PCP): \_\_\_\_\_  
Requesting Provider contact with member's PCP to coordinate integrated care? Yes \_\_\_ No \_\_\_  
Date of contact: \_\_\_\_\_

Date member first contacted: \_\_\_/\_\_\_/\_\_\_ Scheduled initial session on: \_\_\_/\_\_\_/\_\_\_  
Actual initial session (if different from scheduled date): \_\_\_/\_\_\_/\_\_\_ Most Recent Session: \_\_\_/\_\_\_/\_\_\_  
Number of Sessions to Date: \_\_\_\_\_

Diagnosis and DSM-IV code: \_\_\_\_\_

Symptoms: \_\_\_\_\_  
\_\_\_\_\_

Objective and measurable goals: \_\_\_\_\_  
\_\_\_\_\_

Treatment plan and progress: \_\_\_\_\_  
\_\_\_\_\_

Procedure Codes Requested:

- 90804 -Individual Treatment, 20-30 minutes
- 90806- Individual Treatment, 40-50 minutes
- 90847 - Family / Marital Therapy
- 90862 - Medical Management
- 90805 – Medical Management / Individual Treatment, 20-30 minutes
- 90807 – Medical Management/ Individual Treatment, 40-50 minutes
- Other

Frequency Requested:

- Bi-weekly
- Weekly
- Bi-monthly
- Monthly
- Quarterly
- Semi-annual

Medications (Including dosage): \_\_\_\_\_  
\_\_\_\_\_

Signature/Title: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_



*PLEASE NOTE THAT AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT*