HARMONY HEALTHCARE

PHONE (702) 251 – 8000 FAX (702) 471 – 0120

INITIAL AUTHORIZATION REQUEST FOR MEDICATION THERAPIES

Date of Request:________________________________ Clinician: _______________________________

Client Name:___________________________________ Insurance Plan:___________________________

SS # _________/_______/_________ D.O.B.: ________/______/________

Current problems/Functional impairments (please use specific examples of the nature of patient's deficits in everyday living that require continued treatment, including occupational, marital/family, interpersonal/social, school and/or self maintenance; please provide symptoms and behaviors that support the diagnosis below, including severity, frequency, and duration)____

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Current diagnosis: Full Axis 1 – 5 diagnosis required, including current and highest GAF

__________ Axis I __________ Axis II __________ Axis III __________ Axis IV ________/________ Axis V

current/highest last 6 mo.

Goal GAF:________

Psychosocial treatment recommendation:____

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For FHP/PacifiCare ONLY: When medications are prescribed, please call (800) 367 – 7965 to pre-authorize the reimbursement for the patient. Some medications are not on PacifiCare's approved formulary and must be pre-authorized for payment.

Thank you.

Current treatment plan and strategies/medication therapy (type and dosage):___________________________________

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Anticipated Maintenance Goals:

____brief short-term medication therapy
____following medication adjustments (refer to PCP for maintenance)
____complicated case, maintain in medication management on going
____medication therapy not indicated
____estimated # of service units to achieve above goal and time period:
number of 90862's ______from________to_________
number of 90841's ______from________to_________
number of 90805's ______from________to_________

Clinician/Doctor Signature: ____________________________________ Date: ___________________________