HARMONY HEALTHCARE
PHONE (702) 251 – 8000 Opt. 5 FAX (702) 366-0269
AUTHORIZATION REQUEST FOR
MEDICATION MANAGEMENT

Client Name: _____DOB: _____/_____/_____ Circle: Male /Female

Address: _____Phone_____

SSN_____/_____/_____ Employer: _____

Insured Name_____ Primary Ins._____ ID#_____

Secondary Ins. _____ID#_____

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)_____

_____

_____

_____

Specifiers: (Severe, Moderate Diagnostic Code: _____ Specifiers: (Severe, Moderate Diagnostic Code: _____

Features: (Recurrent, Psychotic Features: (Recurrent, Psychotic

Psychosocial treatment recommendation: _____

_____

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

_____

_____

_____

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 99213's ___ _____ From_____ To_____

Number of 90792's __ _____ From_____ To_____

Provider Name & Title: (Print) _____Fax #_____

Clinician/Doctor Signature: _____Date: _____