INITIAL TREATMENT AUTHORIZATION REQUEST

HARMONY HEALTHCARE

PHONE (702) 251-8000 Opt. 5 FAX (702) 366-0269

Client Name:_____ Date of Birth:_____ Age:_____ Gender:_____

Complete Address:_____Phone:_____

SSN_____/_____/_____ Insured Name:_____Employer:_____

Primary Insurance: _____ ID#:_____

Secondary Insurance: _____ ID#:_____

Primary Diagnosis (ICD-10/F-Code ONLY):_____ **Secondary Diagnosis (ICD-10/F-Code ONLY):_____**

Suicidal or homicidal: Yes_____ No_____ If Yes: Plan _____ Intent_____ Means_____

Depressive Symptoms: Mild____ Moderate_____ Severe_____ Crying_____ Fatigue_____ Appetite Change_____ Sleep Disturbance_____

Anxiety Symptoms: Mild____ Moderate____ Severe_____ Panic Attacks_____ Excessive Worry_____ Restless_____ Compulsive Behavior_____

Psychotic Symptoms: Paranoid_____ Delusional_____ Bizarre Behavior_____ Hallucinations: visual____ auditory____ command_____

ADHD Symptoms: Mild____ Moderate____ Severe____ Distractible____ Forgetful____ Disorganized_____ Careless_____ Fidgety_____

Aggressive Behavior: Physical_____ Verbal_____

Family/ Marital Problems: Mild_____ Moderate_____ Severe_____

Was Client Screened for Substance Abuse/ Gambling? Yes_____ No_____ Problem Indicated? Yes_____ No_____

Substance: _____ Severity: Mild_____ Moderate_____ Severe_____

Is client currently on psychotropic medication? Yes_____ No_____

Start date for this PAR (*must be within 60 days of this submission*): _____Approx. # of sessions to complete Treatment: _____

Provider Name & Title (print):_____ Fax #_____

Provider signature (***required***): _____ Date: _____

PLEASE WRITE IN THE NUMBER OF SESSIONS REQUESTED (Maximum of 20):

___(90791) **Frequency of sessions should NOT exceed 1x/week. If more than 1x/week**

___(90834/90847/90853) **is needed please contact Provider Services with additional information so**

___Total (*cannot exceed 20)* **so that we can notate the account.**

PLEASE NOTE: Prior Authorization is the determination of the medical necessity and appropriateness of treatment as a required part of the Utilization Management process. Prior authorization approval by Harmony Healthcare does not automatically ensure payment. Even if a service has been prior approved, the provider must still verify a recipient's eligibility by contacting the insurance carrier or obtaining online verification of active coverage on the day the service is provided. If you do not verify the eligibility and extent of coverage of each recipient each time services are provided, then you will risk the possibility of nonpayment for your services.