



Washington County Health and Human Services

Authorization Request Form

This form is for use after **January 1, 2009**

Type of Authorization:

<input type="checkbox"/> Initial Authorization		<input type="checkbox"/> Continued Treatment Authorization	
Provider Agency:		Location:	
Auth Start Date:		Auth End Date:	

Client Information:

Last Name:		First Name:	
DOB:		SSN#:	
Primary and Secondary Diagnoses:	1: 2: 3:	LOCUS/CASII Score: (if applicable)	
		Ethnicity:	

Funding: *(please complete all that apply)*

<input type="checkbox"/> OHP #:
<input type="checkbox"/> Medicare #:
<input type="checkbox"/> General Fund: #:
<i>(Please complete an Income Verification Form and attach to documentation)</i>
<input type="checkbox"/> Other Coverage (Private Insurance, VA, etc.): Carrier: _____ Policy #: _____

Authorization Type Requested: *(Please refer to the WaCo policy for service type criteria)*

OHP and General Fund:	OHP Only Auth Types:	GF Only Auth Types:
<input type="checkbox"/> Rehab: Level I* <input type="checkbox"/> Rehab: Level II* <input type="checkbox"/> Rehab: Level III (ICS)* <input type="checkbox"/> Geriatric Rehab <input type="checkbox"/> Child Level I Brief Treatment** <input type="checkbox"/> Child Level II Outpatient ** <input type="checkbox"/> Child Level III Intensive** <input type="checkbox"/> Trans. Age Youth Intensive */** <input type="checkbox"/> Early Psychosis <i>* Requires LOCUS</i> <i>** Requires CASII</i>	<input type="checkbox"/> St. Mary's Home for Boys <input type="checkbox"/> Kerr Group Homes <input type="checkbox"/> Outpatient Adult <input type="checkbox"/> Geriatric Outpatient	<input type="checkbox"/> School Based Screening and Referral <input type="checkbox"/> Health Clinic Adult Screening and Referral <input type="checkbox"/> Health Clinic Child Screening and Referral <input type="checkbox"/> Adult Rehab Assessment Only <input type="checkbox"/> Child Outpatient Assessment Only

All services must be pre-authorized. Attach a current treatment plan and assessment when required by Washington County policy. Please complete LOCUS or CASII instrument if applicable and submit score with request. Requests will not be processed without required documentation of if this form is incomplete. Please fax form and documentation to **503-846-4560**.

Clinical Supervisor Signature: _____ Date: _____

For internal use only: Date Received: _____ Date Processed: _____ PHTech reference #: _____
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