Prior Authorization Request for Ryan White Mental Health Services

Fax completed form and Release of Information to: Dr. Uyen Hoang at (714) 834-8395 Phone: (714) 834-7991

Patient Information

Patient Name: _____ Birth date: _____
First M.I. Last

Address: _____
Street City Zip Code

Phone: ( ) - Gender: ☐ Male ☐ Female ☐ M to F ☐ F to M

Provider Information

Provider: _____ Office Contact: _____

Address: _____

Phone: ( ) - Fax: ( ) -

Director of Mental Health: _____ Signature: _____

Service Request Information

Brief Mental Health History, including DSM IV Diagnosis:

_____

_____

_____

Initial Treatment Goals:

_____

_____

Treatment Goals Achieved:

_____

_____

Treatment Goals not Achieved. Please describe barriers to goals that have not been achieved (psychosocial, therapeutic, etc.).

_____

_____

Current Treatment Goals:

_____

_____

Client's insurance source, if applicable: _____

Number of sessions provided this fiscal year: _____ Number of additional sessions requested (up to 10): _____

DO NOT WRITE BELOW THIS LINE - FOR HCA USE ONLY

Authorization Decision Status

☐ Approved. Number of additional sessions (up to 10) approved: _____

☐ Denied. Describe in comments below.

☐ Deferred for more information. Describe additional information needed in comments below.

Comments:

_____

_____

Authorizing Signature: _____ Date: _____

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