BHRS CHILD/ADULT MEDI-CAL REAUTHORIZATION AND CHANGE OF SERVICE MODALITY REQUEST FORM

Fax To: 415 473-2353

Reauthorization request must be received 10 business days before expiration of prior authorization

Date:		Clinician:		
Provider/Agency:		Telephone:		Ext.
		Supervisor:		

Client Data:

Client Name:		Date of Birth:	
SS#:		or Medi-Cal#:	

Diagnosis:

Diagnoses: DSM5 code and written description		
	DSM 5 code	**Description**
Primary Dx		
Secondary Dx		
Tertiary Dx		
Substance Abuse/Dependence: Yes ☐ No ☐		

Diagnosis has been changed from the initial Access Team Referral (if applicable): Yes ☐ No ☐

Date of initial Access Team (or MMHP) referral ___________________

Treatment Info:

Requested Start Date of the reauthorization	
Date of most recent assessment	
Date of most recent treatment plan (signed by the client)	
# of sessions requesting	
Type of treatment modality (i.e.: family, PCIT, PPP, trauma, group, individual)	

1. **Current Mental Health symptoms and rationale for requesting additional sessions/change of modality:**

Client Name:	
Client MR #:	

2. Progress toward meeting objectives from previous treatment plan:

3. Impairment in functioning (Include all that apply. ***Provide an explanation in box below.)***

☐ Occupational/Educational ☐ ADLs Activities of Daily Living ☐ Family and Social Relationships
☐ Housing ☐ Health ☐ Severity of Symptoms
☐ History of Psychiatric Hospitalizations ☐ Probability of Deterioration in an Area of Life Functioning

4. Psychiatric medications and Medical/ Health Issues, if any:

Remember: You must submit an assessment with a client plan to obtain approval for reauthorization.

- **The client plan MUST include objectives which are specific, measurable, and observable.**
- **The interventions on the client plan MUST include frequency and duration.**
- **The client plan must be SIGNED by the client.**
- **Supervisor Signature is required for all intern staff.**

____________________ ____________________
Clinician Supervisor

____________________ ____________________
Date Date

Client Name:	
Client MR #:	