

## Network Health Plan Outpatient Treatment Request for Behavioral Health Services—Initial

Use this form to request authorization for outpatient sessions after you have completed your initial evaluation.

Please complete the member and rendering provider information boxes below.

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.

Address: Network Health Plan 1570 Midway Place, Menasha, WI 54952. Attn: Behavioral Health Care Management Department

Provider questions: (920) 720-1340 or (800) 555-3616

MEMBER INFORMATION	RENDERING PROVIDER INFORMATION
Member's Name:	Provider Name :
Member DOB:	Provider Fax #:
Member ID #:	Provider Phone #:
Primary Diagnosis:	Requested Auth Start Date:

### Information below to be completed by NHP staff only

Authorization Number	Effective Date of Authorization	Number of Sessions Authorized	End Date of Authorization	NOTES
				Any additional sessions authorized will be added to this episode of care using the same authorization number when possible. If further sessions are needed, please complete the Outpatient Treatment Request-Concurrent.

<b>CM Referral Tech</b>		<b>Date Authorized</b>	
-------------------------	--	------------------------	--

Reviewed by Behavioral Health Coordinator? Y \_\_\_\_\_ N \_\_\_\_\_

<b>BH Coordinator Signature:</b>		<b>Date Reviewed:</b>	
----------------------------------	--	-----------------------	--

**BHCM NOTES:**