Date of Form Submission:

Notification Review for Additional Outpatient Mental Health Service

This request is to only be used for **ADDITIONAL OUTPATIENT SERVICES** for a client. Requests for new outpatient services should be directed to TEAM using the "Notification Review for New Outpatient Services" at www.team-mn.com. ***Please print clearly. Incomplete or illegible forms can not be processed.***

Client's Name	**Clinician Name**
Client's Date of Birth	**Degree & License Type**
Client's Address	**Provider Name**
Client's Phone #	**Provider Address**
Policy Holder's Name	**Provider Phone #**
Group #	**Provider Email Address & Fax #**
ID#	**Diagnoses**

Measurable Objective	Method for Achieving Objective	Progress *	Resolution Date

***Progress Rating Scale: N-New Objective 1-Decreased 2-Improvement 3-Resolved**

Suicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent ☐ Ideation in Past Year ☐ Attempt in the Past Year

Homicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent ☐ Ideation in Past Year

Substance History (indicate drug/s of choice): _____

Current Frequency of Visits:

_____

Services Requested (Include # of sessions needed; not to exceed 6): 90804: _____ 90805: _____
90806: _____ 90847: _____ 90853: _____ 90862: _____ Other: _____

Psychotropic Medication(s) and Dosage(s): _____

_____ _____

Clinician's Signature **Date**

Submit completed forms via email or fax to TEAM

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