**Date of Form Submission:**

# Authorization Request 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 "Authorization Request 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**

**TEAM Corporation**
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