



Notification Review for Day Treatment or Partial Hospital Program

This request is to be used for **NEW AND CONTINUING SERVICES** for a client. Treatment plan must accompany this request. *Please print clearly. Incomplete or illegible forms can not be processed.*

Client Information

Client's Name

Client's Date of Birth

Client's Address

Client's Phone #

Group #

ID #

Policy Holder's Name

Presenting Issue/Diagnosis

Provider Information

Type of Program (CD, MH, MI/CD)

Expected Length of Program

Clinical Hours Per Day Spent With Licensed Provider

Total Hours Per Day Spent in Program

Name and Address of Organization

Name of Requestor

Requestor's Phone #

Requestor's Email Address & Fax #

Requested Start Date of Service

Additional Comments:

IMPORTANT: Treatment plan must accompany request in order to authorize treatment.

Submit completed forms via email or fax to TEAM