

STATE OF NEW HAMPSHIRE

APPLICATION FOR PRIOR AUTHORIZATION OF PSYCHOTHERAPY SERVICES IN EXCESS OF THE SERVICE LIMITS

CONFIDENTIAL

PROVIDER NAME: TITLE:

PROVIDER PIN # OR GROUP PIN # (\*Used for billing information.)

MAILING ADDRESS: Street City State Zip Code

TELEPHONE #: Extension:

RECIPIENT'S NAME: DOB:

MAILING ADDRESS: Street City State Zip Code

TELEPHONE #: - -

RECIPIENT'S MEDICAID (Title XIX) NUMBER:

DIAGNOSIS:

DSM IV-R AXIS I: AXIS II: AXIS III: AXIS IV: AXIS V:

MEDICATION: DOSE: FREQUENCY:

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HAS A PRIOR AUTHORIZATION BEEN REQUESTED ON BEHALF OF THIS INDIVIDUAL DURING THIS FISCAL YEAR (7/1-6/30)? YES NO AUTHORIZATION #

IS RECIPIENT ALSO COVERED UNDER MEDICARE? YES NO

DOES A CONTRACTED HMO MANAGE RECIPIENT'S MEDICAID? YES\* NO

IF YES, NAME OF THE HMO (\*Include statement from insurance company verifying that benefits have been exhausted.)

HISTORY:

LEVEL OF FUNCTIONAL IMPAIRMENT:

WHY ARE SERVICES MEDICALLY NECESSARY?

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TREATMENT PLAN: (Include time frames and progress information.)

PROBLEM LIST

TREATMENT GOAL

METHOD AND FREQUENCY  
OF INTERVENTION

ARE THERE EXTENUATING CIRCUMSTANCES? IF YES, PLEASE ADVISE:

IN THE CASE OF A CHILD, IS HE/SHE CODED? YES \_\_\_ NO \_\_\_

DOES HE/SHE HAVE AN IEP? YES \_\_\_ NO \_\_\_

IS TREATMENT PART OF THE IEP? YES \_\_\_ NO \_\_\_ (A copy of the IEP must be included.)

DO YOU CONSULT WITH THE SCHOOL REGARDING THIS CHILD? YES \_\_\_ NO \_\_\_

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IS CASE OPEN TO DCYF OR DIVISION OF JUVENILE JUSTICE? YES \_\_\_ NO \_\_\_

IF YES, DOCUMENT NAME OF CONTACT OR REFERRAL INDIVIDUALS: \_\_\_\_\_

SPECIFIC REQUESTS ABOVE THE SERVICE LIMIT: Identify each service to be billed, name, and provider number. Each service must be identified with the number of sessions requested. (The start date is the 13<sup>th</sup> visit for psychotherapy services provided by ARNPs, pastoral counselors, social workers, and psychologists. The start date is the 19<sup>th</sup> physician/psychiatrist visit, i.e., psychiatrist and physician services are combined and count toward the physician service limit of 18 visits.)

THERAPIST	PROVIDER # (PIN#)	BILLING CODE	START DATE OF EXTENDED SERVICE	# OF SESSIONS YOU ARE REQUESTING
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____

**DOCUMENT BELOW THE NUMBER OF ANTICIPATED SESSIONS PER WEEK, MONTH, ETC. (This information must be completed as accurately as possible.)**

OTHER PROVIDERS:

NAME	TITLE/LICENSE	AFFILIATION/SERVICE PROVIDED
1.	_____	_____
2.	_____	_____

Approval of this application is a determination that the services requested are medically necessary. Recipient eligibility and provider enrollment determine final payment status and amount. Approval is not an authorization for payment.

\_\_\_\_\_  
PROVIDER SIGNATURE TITLE DATE

**PLEASE RETURN COMPLETED FORM TO:**

JOY CADARETTE  
105 PLEASANT STREET  
DIVISION OF BEHAVIORAL HEALTH SERVICES  
CONCORD, NEW HAMPSHIRE 03301  
(603) 271-0800  
1-800-852-3345 ext. 0800 (in-state only)