

Continued In-home Treatment Prior Authorization Request Form

HealthPartners CANNOT accept a completed form via e-mail. Can only accept via fax or US mail.

Name of Member to Receive Services:	Member's Insurance ID #:	Member's DOB:
Provider Name / Degree/ License	Phone #:	Fax #:
Address:	Tax ID #:	NPI #:
Is provider Supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a Rule 29 clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Supervisor / Degree/ License	
Is this care being provided in the home?		
If yes, why does care need to continue in the home and not in the office?		
If yes, when will the member be ready to transition care to the office?		
Circle codes requested: 90834 90846 90847 90853	Requested Start Date:	
<u>Current and Provisional DSM-5 / ICD-10 Diagnosis (es)</u>		
<u>Current symptoms for each diagnosis with frequency/intensity AND Progress on symptoms since last authorization:</u> (E.g. Difficulty sleeping – was averaging 4-5 hrs 7/7 nights and is now sleeping 6 hrs a night 4/7 nights x 2 wks)		
<u>Current measurable goals with how you are measuring them AND Progress on treatment goals since last authorization:</u> (E.g. Goal 1: Decrease depr as reflected by a Beck Depr Inventory score of 10 or less. Last review was a 19 and now is at a 13 x 2 wks)		
<u>How will you know that the member is ready to terminate treatment?</u> (E.g. BDI of 10 or less for 3 months)		
<u>Medication changes and dates:</u>		
Estimated termination date:		
Form completed by:	Date:	Phone #: