SAN BERNARDINO COUNTY
DEPARTMENT OF BEHAVIORAL HEALTH

Please print or type

OUTPATIENT TREATMENT *RE*AUTHORIZATION REQUEST FOR ADULTS

Every item must be completed. Please FAX to (909) 386-0775.

Client Name: ____________________ DOB: ____________

SSN: ____________ Financial/Insurance Status: ____________

Address ____________________ City & Zip Code ____________

Telephone Number ____________________ SIMON # ____________

Clinic ____________________ Primary Clinician ____________

Primary Clinician Telephone Number ____________________

Current Client Services		
Type of Service	Frequency	Beginning Date

Services For Which REAuthorization Is Being Requested				
Type of Service	Frequency	Length of Service Period	# of Sessions Already Completed	# of Visits Requested

How have the services authorized on the initial TAR benefited the client? Identify treatment goals and attempts made to accomplish goals

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Current Problems Which Require An Extension of Previous Authorization (Note: If client did not make progress as expected towards identified goals, please submit chart notes and any additional information describing barriers to progress, as well as efforts made to eliminate these barriers.)

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Outpatient Treatment REAuthorization Request--Adults

Client Name ______________________

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Please describe your rationale for the authorization request you are making: ______________________

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Why would a different service activity not be appropriate for this client? (For example, if you are requesting authorization for day treatment services, please explain why group therapy and referral to a clubhouse would not constitute an appropriate set of alternatives.)

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Please describe your plan for a transition to a different service activity ______________________

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Please identify referrals you have made to help support client (e.g., to community agencies, self-help groups)

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Current Medications			
Medication	Dosage	Frequency	Target Symptoms

Other Providers/Agencies Providing Services to Client: ______________________

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Outpatient Treatment REAuthorization Request--Adults

Client Name ______________________

DSM-IV DIAGNOSES		
	DSM-IV Code	Diagnosis/Description
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		GAF Score =

Clinic Supervisor Signature ______________________ Date ____________

SERVICES APPROVED		
Type of Service	Authorization Expires On	Number of Visits Approved

☐ First Reauthorization ☐ Second Reauthorization ☐ Third Reauthorization

SERVICES NOT APPROVED		
Type of Service	NOA Issued	Date NOA Issued

REFERRALS PROVIDED

Access Unit Staff (Printed) ______________________

Access Unit Staff Signature ______________________ Date ____________

[If you have any questions regarding the actions taken by the Access Unit, please telephone (909) 421-9272 and ask to speak with the clinician whose name appears above.]

NOTE: Please submit your request for REauthorization at least 14 days prior to the expiration of the current authorization.