

**Montana Mental Health Services Plan
Adult Intensive Outpatient Services
Continued Stay Authorization Request Form**

To transmit request information:		Or Mail To: AMDD Benefit Management Team PO Box 202905 Helena MT 59620	
FAX: 1-406-444-7391		Attn: Linda Nelson	
PLEASE PRINT OR TYPE			
Units Requested		Start date:	
H0046 HB		Individual or family therapy sessions	=> 90 units max.
H2014		1:1 DBT coaching & case management	=> 90 15-min. units max.
H2014 HQ		DBT skills group sessions	=> 260 15-min. units max.
CLIENT INFORMATION			
Client Name:		MHSP Number:	
DOB: / /	Gender: M F		
PROVIDER INFORMATION			
Primary Therapist's Name:		NPI Number:	
Telephone Number:		Fax Number:	
MHC Name:		NPI Number:	
City:		Zip Code:	
CLINICAL INFORMATION			
<i>Has the DSM Diagnosis Changed since last request?</i> NO YES If yes, list below			
Axis I	Code	Narrative	
	Code	Narrative	
Axis II	Code	Narrative	
<i>Check any services utilized by this individual within the past 90 days:</i>			
Acute Psychiatric Hospital	<input type="checkbox"/>	Adult Day Treatment	<input type="checkbox"/>
State Hospital (MT or other)	<input type="checkbox"/>	Adult Group or Foster Home	<input type="checkbox"/>
Crisis Stabilization	<input type="checkbox"/>	Medication Management	<input type="checkbox"/>
Emergency Room	<input type="checkbox"/>	Crisis Line	<input type="checkbox"/>
Chemical Dependency Treatment	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Medication Changes, if any:			
Current Psychological Symptoms, Behavior, and Level of Functioning:			

Processing may be delayed if information submitted is illegible or incomplete

Revision 02/09

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<i>Changes to Treatment &/or Crisis Plan:</i>
<i>Brief summary of client's progress in Intensive Outpatient Treatment:</i>

I certify that I have reviewed the Clinical Management Guidelines for Intensive Outpatient Therapy Services as and that this client meets these guidelines at this time.

Assessment completed by (please type or print):	
Signature:	Date: