MENTAL HEALTH AND SUBSTANCE ABUSE OUTPATIENT REAUTHORIZATION

DEPARTMENT OF SERVICES FOR CHILDREN, YOUTH & THEIR FAMILIES
DIVISION OF PREVENTION & BEHAVIORAL HEALTH SERVICES
1825 Faulkland Road Wilmington, DE 19805 (302) 633-2571 or (302) 633-2591

Please fill out this form completely and call if you need assistance.

Fax this form to (302) 622-4475

Client Name _____ DOB:_____

Admission Date _____ Facility/Program _____

If child is uninsured you must provide documentation regarding efforts made to obtain Medicaid including date of application, dates of calls made to check on status, denial letter, missing information letter, etc.

Total Number of sessions scheduled this past authorization period _____

Number of sessions cancelled by family _____

Number of sessions cancelled by therapist _____

Number of No Shows by Client/Family _____

Client's diagnosis (DSM IV including codes):

What has the client been treated for?

What are the treatment goals?

What has been improved upon?

What still needs to be addressed?

Therapist Signature _____ Date_____