VIVA HEALTH®

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Pre-Service Authorization/Continued Authorization Request Form

Today's Date: _____

Member Demographics

Name: _____ American Behavioral ID #: _____

Date of Birth: _____ Phone #: (_____)_____

Provider Demographics

Name and Licensure: _____ Phone #: (_____)_____

Fax #: (_____)_____ Place of Service: _____
e.g. Outpatient Office, SNF, etc.

If you have more than one practice address, please list the address at which the requested services will occur/occurred:

_____

Requested Services:

CPT Code	# of Units Requested	Date Range	
		From	To

Please attach a separate sheet(s) of paper if you require more room.

****

Patient Name: _____ **Pt. ID #:** _____

MDs, DOs, & Nurse Practitioners

1. Evaluation and Management

A. Problem-focused history

B. Problem-focused examination

C. Evidence of straightforward medical decision making

Patient Name: _____ **Pt. ID #:** _____

All Licensures

2. Multi-axial Diagnoses

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____ **Axis V:** _____

3. Please explain the intensity of service for this patient.

4. Please list a minimum of three (3) goals set by or for this patient.

5. Please indicate how you measure the progress of each goal for this patient.

****

Patient Name: _____ **Pt. ID #:** _____

6. Please indicate the patient's progress toward his or her goals.

7. Please list all second opinions you have on file for this patient.

8. If you have attempted to decrease the frequency of visits or increase the length of time between each visit, please provide the trigger for the need to increase the frequency of visits for this timeframe.

****

Patient Name: _____ **Pt. ID #:** _____

9. List the most current dates that the patient has been seen by the following:

Physician/Clinician/Support Group	Name and Licensure	Most Current Date of Service
PCP/General Practitioner/Internal Medicine Practitioner		
Medical Specialist(s)		
• Specialty:		
• Specialty:		
Psychiatrist		
Psychologist		
Counselor		
Support Group(s) • Name: _____ • Name: _____		

10. List all current medications.

Medication	Dose	Route	Frequency

****

Patient Name: ______________________________ Pt. ID #: ________________

11. Please note any additional information you would like to add.

Thank you for your response.

******************************FOR VIVA HEALTH USE ONLY******************************

CPT Code	Units Approved	Authorization #	Authorization Start Date	Authorization Expiration Date

Payment of benefits is subject to eligibility at the time services are rendered according to the terms of the benefit contract and payment is subject to retroactive eligibility verification.