PM FORM 10.14.1

White Mountain Apache Tribal Regional Behavioral Health Authority
Service Authorization

This form is to be completed by ABHS staff only. The effective date for this form is October 1, 2007. For Level I and Level II **under** 21 years of age submit form to ADHS/BQMO at Fax: **(602) 364-4697** along with Prior Authorization form. For Level II for 21 years or older, Level III and other services that **do not** require Prior Authorization this form is to be submitted to ABHS Quality Management Administrator for Authorization.

Service Plan #: _____ **AXIS I:** _____ **Provider:** _____

Date: _____ **AXIS II:** _____ **Provider Therp/CM:** _____

Client Name: _____ **AXIS III:** _____ **TRBHA CM/OHP Coor:** _____

Intake Date: _____ **AXIS IV:** _____ **PCP Name/ID #:** _____

AHCCCS ID #: _____ **AXIS V:** _____ **AHCCCS Health Plan:** _____

Client ID: _____ **Review Date:** _____ **Health Plan ID #:** _____

Soc. Security #: _____ **AUTHORIZATION #:** _____

Member Population: (select one)

Child ☐ SMI ☐ Mental Health ☐ Substance Abuse ☐

APP CODE	ACT CODE	SERVICE TYPE	FUND TYPE	SERVICE CODE	SERVICE DESCRIPTION	PROVIDER NAME	PROVIDER ID	BEGIN DATE	END DATE	# UNITS REQ.	# UNITS APP	COST

APP CODE: A = Approved D = Denied C = Change N/A = Not Applicable

ACT CODES 1= Add 2= Change **Authorizing Signature:** _____

Date

1. Child: a.) ☐ T19 ☐ Non-T19 b.) ☐ Case Mgmt. ☐ Case Coord. 2. SMI: a.) ☐ T19 ☐ Non T-19 3.) Adult: ☐ MH ☐ DR ☐ ALC ☐ DV