



ALL INFORMATION IS REQUIRED FOR AUTHORIZATION.
 AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.
 REIMBURSEMENT DEPENDS ON ELIGIBILITY AT THE TIME OF SERVICE.

Submitted By:

Name: *(print)* _____

Facility: _____

Phone: _____ Tax ID #: _____

Provider Fax: _____

ABC-Denver Fax: (720) 744-5130

.....Date Submitted: _____

CONSUMER INFORMATION (Please Print)

Last Name:		First Name:		Gender:	Age:
Member ID #:	Medicaid ID #:	SSN:	DOB:		
Legal Guardian:			Phone:		
Parent/Foster Parent:			Home Phone:		
Address:		City:	State:	Zip:	
<input type="checkbox"/> ABC <input type="checkbox"/> CHP+ <input type="checkbox"/> DHS Core <input type="checkbox"/> CPA Consumer <input type="checkbox"/> Goebel <input type="checkbox"/> Additional Insurance:					
Primary diagnosis:			Secondary diagnosis:		

THIS C&T IS FOR:

- Initial Authorization for Routine Outpatient Care
- Initial Authorization for All Other Levels of Care
(complete authorization application if checked)

SERVICE TYPE:

- Routine *(must offer appt. within 7 calendar days)*
- Urgent *(must see consumer within 24 hours)*
- Emergent *(must see consumer within 1 hour urban/suburban, 2 hours rural)*

FOR ROUTINE OR URGENT SERVICES:

Date/Time of the Consumer's/Guardian's Request for
 Mental Health Services: _____

Date/Time of First Offered Appt.: _____

Date/Time of First Scheduled Appt. *or* Program Start Date:

FOR EMERGENT SERVICES:

Initial Request for Emergency Services:
 Date: _____ Time: _____

Face-to-Face Evaluation by Mental Health Clinician:
 Date: _____ Time: _____

Dispo: _____

If your appointment or evaluation does not meet the above timeframes for access to services, please explain the reason for the delay: _____

For routine or urgent care, you must offer a referral to ABC if you cannot meet the required timeframes for access to services. Referral offered? Yes No

For routine care, does the the consumer/family member/guardian have any specific treatment requests?

<input type="checkbox"/> None requested when asked	<input type="checkbox"/> Therapist:	<input type="checkbox"/> Clinician language:
<input type="checkbox"/> Day and/or time:	<input type="checkbox"/> Clinician gender:	<input type="checkbox"/> Clinician specialty:
<input type="checkbox"/> Service location:	<input type="checkbox"/> Clinician ethnicity:	<input type="checkbox"/> Other:

SERVICES REQUESTED:

<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Medication Management	<input type="checkbox"/> Residential	<input type="checkbox"/> Emergency/Crisis Eval
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Home-Based Services	<input type="checkbox"/> ATU	<input type="checkbox"/> Observation
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Inpatient	<input type="checkbox"/> CPA MHNA (PP only)
<input type="checkbox"/> Case Management	<input type="checkbox"/> Respite	<input type="checkbox"/> Other:	