Hennepin Health

DIAGNOSTIC ASSESSMENT AUTHORIZATION REQUEST FORM Complete this form to request additional units beyond 2 per calendar year.

Phone: 612-596-1036 Fax: 612-677-6222

Member Name: ______________________________________ **Provider Name**: ___________________________________

Member ID #: ____ **Degree/License Type:** _______________________________

Member Date of Birth: __________________________________ **Clinic Name**:______________________________________

Is this treatment court ordered? O Yes O No
(If yes, submit order and evaluation, complete Services below)

Provider Phone #: ___________________________________

Provider Fax #: _____________________________________

Referred by: O PCP O Family O County O Self O Other _________

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Release of information for PCP signed: O Yes O No O Refused O Has no PCP If yes, PCP Name:_______________________

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Prior Treatment, in the past year: (# of episodes) MH: Inpatient___ Partial (PHP)___ Day Treatment (IOP)___ Outpatient___ Other___________

CD: Inpatient___ Outpatient___ Other____

CD Treatment Outcome: O completed/sober O completed/still using O Discharged AMA O Active in CD support group

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Diagnostic: Complete:

Axis I: ____

Axis II: ____

Axis III: ____

Axis IV: ____

Axis V: ____

Assessment date: __________________

Risk Assessment: (check if applicable)

O Suicidal O Homicidal O Both (in the last 5 visits)
- O Ideation no plan
- O Ideation w/plan no means
- O Ideation w/plan w/means
- O Attempt

O Family/peer history of suicide
O Family history of CD
O History of abuse: O Physical O Sexual
O Elder neglect

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Services:

90791 Date of Service ___________ Modifier(s)_______

90792 Date of Service ____________Modifier(s)_______

Hennepin Health has a 2 unit diagnostic assessment limit per year. Please document need for additional visits:

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Provider Signature and Date____

Supervisor Signature and Date (if applicable)____

Fax completed form to Hennepin Health Medical Administration at 612-677-6222