

Children Come First/Community Partnerships, Inc.

Prior Authorization/Progress Report

(Prior authorization not to exceed 90 days, must be received prior to service being authorized and to be used for the following CCF service codes: 5100-Individual Therapy, 5101-Individual AODA Therapy, 5110-Family Therapy, 5120-Group Therapy, 5121-Group AODA Therapy, 5130-Special Therapy, 5135-Specialized Offender Treatment, 5160-In-Home Treatment, 5165-Family Preservation, 5170-Day Treatment, 5171-Day Treatment-AODA, 5172-Transitional Day Treatment)

Please submit to:
 Community Partnerships
 1334 Dewey Court
 Madison, WI 53703
 Attn: Prior Authorization
 or
 e-mail to: pa@commpart.org
 fax to: 608-250-6637

Check One: <input type="checkbox"/> Initial PA Request (date range requested, 0-90 days) :		<input type="checkbox"/> Reauthorization (date range requested, 0-90 days):	
Provider/Agency Name:		CCF Service Code Requested (see above):	
Client Name:		CCF Coordinator:	
Date of Birth:			
Diagnoses:	Axis I:	Axis II:	
	Axis III:	Axis IV:	Axis V:
Medications and Dosages:			
MD Prescribing Medication Currently:			
Are there barriers preventing progress toward goals (ex. missed appointments, transportation, etc.)?:			

Therapy Goal(s) for this authorization period <small>(please check the duration of this goal)</small>	Intervention <small>Treatment Modality (Individual, family, group, insight, play, experiential, etc.)</small>	Progress (list progress for reauthorization request only) <small>(please include observable strengths during this authorization period and how cultural considerations are being incorporated into the treatment process) Please use the back of this form if more space is needed</small>
1. <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> over 12 months	_____	_____
2. <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> over 12 months	_____	_____
3. <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> over 12 months	_____	_____
Provider Signature or Typed Name:		Date:

For office use only:	Rev. 12/27/04
<input type="checkbox"/> PA/PR approved for the following time period _____	<input type="checkbox"/> PA/PR denied due to _____

Additional Progress

(please include observable strengths during this authorization period and how cultural considerations are being incorporated into the treatment process)

Please use the back of this form if more space is needed

Goal 1

Goal 2

Goal 3