



Outpatient Treatment Registration Form For Substance Abuse Services

Gateway Health Plan® 1-866-755-7299 Fax: 717-540-1146

Requests need to be submitted within 5 business days of requested service start date (4:00 p.m. fax cutoff)

Member Name: _____	Member SSN: _____
Gateway Health Plan® Member ID#: _____	Member DOB: _____
Member Address: _____	Member Phone: _____
Provider Name (billing name): _____	Contact Person: _____
Provider Address (billing address): _____	Provider ID: _____
City, State, Zip: _____	Phone: _____ Fax: _____

Diagnosis Code: _____ **Select One:** Admission Continued Stay Discharge/Referral

Service Requested	Frequency	Start Date	End Date	# used Previous Auth	# Sessions Requested
Diagnostic Interview (90801)	1		N/A	N/A	1
Individual (90806)					
Group (90853)					
Pharmacologic Mgmt. (90862)					
Other (specify code)					

Name/Degree for professional providing 90801/90862: _____

Projected Discharge Date: _____ **Discharge Plan in Place:** Yes No

Indicate level of care & criteria:	<u>Level of Care</u>	<u>Criteria Indicated</u>
Intoxication/Withdrawal:	_____	_____
Biomedical Conditions:	_____	_____
Emotional/Behavioral:	_____	_____
Treatment Acceptance/Resistance:	_____	_____
Relapse Potential:	_____	_____
Recovery Environment:	_____	_____

Member progress or status is required in each dimension (PCPC).

Dimension 1: _____

Dimension 2: _____

Dimension 3: _____

Dimension 4: _____

Dimension 5: _____

Dimension 6: _____

Special Needs Requests: _____

CBHNP USE ONLY: Authorization Number: _____
<input type="checkbox"/> Other: _____