1199SEIU Benefit Funds
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WELLNESS MEMBER ASSISTANCE PROGRAM
PRIOR AUTHORIZATION OR CONCURRENT REVIEW FOR
INTENSIVE OUTPATIENT PROGRAM OR PARTIAL HOSPITALIZATION PROGRAM

This form is fillable: Please type in your information. Complete the form and attach copies of pertinent clinical documents or copies of the program's actual record to support your request. Fax the completed form, with supporting documents, to (646) 473-6919.

NOTE: Any sections that are not completed will be considered not applicable to your patient and may affect the outcome of this request.

MEMBER NAME _____ MEMBER ID # _____

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE NUMBER _____ HOME PHONE NUMBER _____

TREATING FACILITY INFORMATION

FACILITY NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ FAX NUMBER _____

TAX ID# _____ REVIEWER'S NAME _____ REVIEWER'S PHONE NUMBER _____

Referring Source if Different from Treating Facility _____

Name and Phone Number of Referring Source _____

TREATMENT MODALITY

- ☐ Mental Health Partial Hospitalization Program
- ☐ Mental Health Intensive Outpatient Program
- ☐ Substance Use Disorder Partial Hospitalization Program
- ☐ Substance Use Disorder Intensive Outpatient Program
- ☐ Eating Disorder Partial Hospitalization Program
- ☐ Eating Disorder Intensive Outpatient Program

PLACE OF SERVICE

☐ Virtual

☐ In-person

☐ Hybrid

TYPE OF REQUESTED REVIEW

☐ Initial Review

☐ Concurrent Review

☐ Retrospective Review

Requested start date of this authorization/concurrent review _____

Requested end date of this authorization/concurrent review _____

Number of days requested _____

Number of days per week the patient is attending the program _____

Number of hours per day the patient is attending the program _____

DIAGNOSIS

Primary _____

Secondary _____

Tertiary _____

Medications _____

_____

_____

Please attach relevant clinical information with this form, including assessments, individual and group notes, psychiatric evaluations, medication records and any other relevant information.

Disclaimer: An authorization does not guarantee payment by the 1199SEIU Benefit Funds. Responsibility of payment is subject to member eligibility, benefit limitations and medical necessity.