REQUEST FOR PRIOR APPROVAL

**PSYCHOTHERAPY**

This form should be filled out and submitted **by the parent** to request prior approval for psychotherapy.

**CHILD INFORMATION:**

NAME: DOB:

PARENTS’ NAMES:

ADDRESS:  PHONE #:

**PROVIDER INFORMATION:**

PROVIDER NAME:

PROVIDER FED ID#/SS#: LICENSE/CERT #:

ADDRESS:

**CONDITION PSYCHOTHERAPY IS BEING PROVIDED FOR:**

**I AM REQUESTING PRIOR APPROVAL FOR THE FOLLOWING SERVICES:**

**\_\_\_\_\_INDIVIDUAL COUNSELING/THERPY**

**\_\_\_\_\_GROUP COUNSELING/THERAPY**

**\_\_\_\_\_FAMILY COUNSELING/THERAPY**

**I HAVE ATTACHED THE FOLLOWING:**

**\_\_\_\_\_UPDATED TREATMENT PLAN**

**\_\_\_\_\_PROOF THAT ALTERNATIVE RESOURCES HAVE BEEN EXHAUSTED**

**(CMH, MEDICAID, PRIVATE INSURANCE)**

**\_\_\_\_\_COPY OF PROVIDERS CURRENT LICENSE IF OUT OF MICHIGAN**

**\*PRIOR APPROVAL COVERS 5 MONTHS OR 20 SESSIONS; WHICHEVER COMES FIRST.**

**\*ADDITIONAL PSYCHOTHERAPY (INDIVIDUAL, GROUP & FAMILY) WILL REQUIRE PRIOR APPROVAL FROM THE ADOPTION SUBSIDY OFFICE**

**PARENT SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_**