AUTHORIZATION FOR RESTORATIVE SERVICES OF COMMUNITY RESIDENCES

- o Initial Authorization
- o Semi-Annual Authorization
- o Annual Authorization

Client's Name:_____

Client's Medicaid Number:_____

ICD 10 Diagnosis:_____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determine the _____ would benefit from provision for mental health restorative services defined pursuant to Part 593 of 14 NYCRR. This determination is in effect for the period of _____ to _____ at which time there will be an evaluation for continued stay.

_____/_____/_____ _____ _____

Month Day Year Name (please print) Licensure #

_____

Signature

- o Check here if client is enrolled in Managed Care and enter primary care physician name and managed care provider identification number.

_____ _____

Physician Managed Care Provider ID #