HUMAN BEHAVIOR INSTITUTE
Full Service Behavioral Health

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DATE:

OUTPATIENT EXTENDED CARE

Fill-out this form entirely. HBI will not be able to authorize continuing care for this member without this information.

PATIENT NAME:	PROVIDER NAME:
PATIENT'S DATE OF BIRTH:	PROVIDER TEL. NO.:
PLAN / ID#:	DATE OF INITIAL EVALUATION:
DIAGNOSIS:	NO. OF VISITS TO-DATE:

START DATE OF CONTINUED CARE:	CPT CODE:	NO. OF VISITS REQUESTED:

☐ Initial or original symptoms:

☐ Current symptoms:

☐ Obstacles preventing advancement of therapy:

☐ If progress is minimal, what changes were made on the treatment plan?

☐ If progress is minimal, have you considered a second opinion or appropriate referral? If yes, to who?

☐ What plans are in place to achieve targeted treatment goals and estimated time-frame for achieving treatment goals?

☐ Are you aware of the American Psychiatric Association's Treatment Guidelines for treating the patient's specific diagnosis?

▼ FOR HBI USE ONLY ▼

☐ Authorized ☐ Declined ☐ Suspend ☐ Other Recommendation	Approved no. of visits:	CPT:
Comments:	Reviewer:	Date: