CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

NAME/MRN

SERVICE AUTHORIZATION FORM

TYPE OF SERVICE CODE

AR	Adult Residential	DTR	Day Treatment Rehabilitative	MHS	Mental Health Service
ASM	Assessment	DTI	Day Treatment Intensive	MS	Medication Support
CM	Case Management	ICC	Intensive Care Coordination	PLN	Plan Development
CR	Crisis Residential	IHBS	Intensive Home Base Services	TBS	Therapeutic Behavioral Services

UR Track:				**UR Trackholder:**				
Start Date	End Date	Type of Service	Name of Provider/Agency	# of Months Approved	Services Changed	Services Denied	**NOA *** Discussed with Client/Provider	Authorized by Date/Initials

Service Provider Signature/Licensure/Designation *Date*

Authorization Committee Member *Date*

*If services are changed or denied, A Notice of Action (NOA) must be sent to the client and/or service provider

Name: _____

MRN: _____

UR Track:				**UR Trackholder:**				
Start Date	End Date	Type of Service	Name of Provider/Agency	# of Months Approved	Services Changed	Services Denied	**NOA *** Discussed with Client/Provider	Authorized by Date/Initials