BIO-BEHAVIORAL MEDICAL CLINICS, INC.

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TREATMENT AUTHORIZATION REQUEST (MD)

BBMC Account #	**Date**:
PATIENT NAME:	**Date of Birth:**
Diagnosis (ICD-10):	**Insurance ID:**
☐ **Additional Sessions** ☐ **Appointment with MD**	**PCP:**

Summary Notes: (Include dates of service under last authorization)

Current Condition-Medication:

ADDITIONAL TREATMENT REQUESTED: ☐ Yes ☐ No If yes, Frequency_____
Number of sessions requested:_____

(Submit request prior to the last visit or expiration date, whichever comes first)

Treatment Plan for Additional Sessions:

Provider Signature:	Phone:	Fax:

CASE MANAGEMENT AUTHORIZATION and NOTES:

Authorization #:	**Sessions Authorized:**
Effective Date:	**Expiration Date:**
	Signature: