# BIO-BEHAVIORAL MEDICAL CLINICS, INC.

**1060 W. Sierra Avenue, Suite 105 Fresno, California 93711**

**Phone: (559) 437-1111 Fax: (559) 437-1119**


## TREATMENT AUTHORIZATION REQUEST

| | |
|---|---|
| **BBMC Account #** | **Date**: |
| **PATIENT NAME**: | **Date of Birth:** |
| **Diagnosis (ICD-10):** | **Insurance ID:** |
| ☐ **Additional Sessions** ☐ **Appointment with MD / TH** | **PCP:** |
| **Summary Notes: (Include dates of service under last authorization)** | |
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| **Current Condition-Medication**: | |
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**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)

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|---|---|---|
| **Treatment Plan for Additional Sessions**: | | |
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| | | |
| Provider Signature: | Phone: | Fax: |

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|---|---|
| **CASE MANAGEMENT AUTHORIZATION and NOTES:** | |
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| | |
| **Authorization #:** | **Sessions Authorized:** |
| **Effective Date**: | **Expiration Date:** |
| | **Signature:** |