



Gambling Treatment Program
REQUEST FOR CLIENT AUTHORIZATION

Choose a box below to Indicate whether this form is an Initial Authorization, an Extension, or an Additional Client Session request.

- INITIAL**
 TIME PERIOD EXTENSION/ ADDITIONAL CLIENT SESSIONS

SECTION 1. PROVIDER INFORMATION

Provider Name: _____

SAP Vendor No. _____ Contract No: _____

SECTION 2. CLIENT INFORMATION

Client ID No.: _____ Admission Date: _____ Sex: Male Female

Is Client insured? Yes No Other _____

Does Provider participate with client's insurance? Yes No N/A (for uninsured clients only)

If "Yes", reason for requesting authorization:

- Client needs help with copay/ deductible
 Insurance does not cover Gambling/ Gaming disorder
 Other _____

If "No", reason for requesting authorization:

- No available in-network provider
 Insurance does not cover Gambling/ Gaming disorder
 Other _____

***Insurances denials require verbal denial before submitting and a written denial must be kept in the client record**

SECTION 3. TIME PERIOD EXTENSION/ ADDITIONAL CLIENT SESSIONS

Current Authorization Expiration _____ No. of Sessions Used: _____ Additional Time Frame Requested: _____
Date: _____ (specify months)

Additional Sessions Requested: _____

Justification: _____

PROVIDER SIGNATURE/ DATE (REQUIRED)

Certified Gambling Counselor (Print) Signature Date

DEPARTMENT OF DRUG & ALCOHOL PROGRAMS USE ONLY

No. of Sessions _____ Authorization _____ Authorization _____
Authorized: _____ Starts On: _____ Expires On: _____

DDAP Authorized Signature Approval Date

DDAP Authorized Signature Approval Date