County of San Luis Obispo Behavioral Health Department

Mental Health Department

NETWORK PROVIDER AUTHORIZATION

Client's Name:

Client's Date of Birth: Primary Language:

Legal Status: Legally Responsible Person:

Relationship to Client: Responsible Person's Phone:

Care Provider:

Client's Address: Apt. #

City/State/Zip:

Does client have home phone? ☐Yes ☐No ☐Unknown

Home Phone: Special calling instructions:

Does client have a work phone? ☐Yes ☐No ☐Unknown

Work Phone: Special calling instructions:

Does client have a cell or another phone? ○ Yes ○ No

Other Phone: Special calling instructions:

CLINIC TREATMENT PROVIDERS:

Assigned Network Provider: Network Provider Phone:

AUTHORIZED SERVICES:

CPT Code	Service Code	Description	Number of Sessions
90791	100	90 min - Assessment	
90832	206	30 min - Individual Therapy	
90834	206	50 min - Individual Therapy	
90837	206	60 min - Individual Therapy	
90847	204	60 min - Family Therapy w/ client	
90846	204	50 min - Family Therapy w/out client	
90882	200	10 min - Case Management	

Date Authorization Begins: Date Authorization Ends:

COMMENTS:

Signatures

Signature	Signature Line Heading	Printed Name	Date
	LPHA		
	Staff Processing		