

Please submit to:
 RISE
 1334 Dewey Court
 Madison, WI 53703
 Attn: Prior Authorization
 or
 E-mail to: pa@risewisconsin.org
 Fax to: 608-250-6637
 or
For all ARTT CCF enrollees:
 Fax to: 608-288-2405

Children Come First - RISE

Prior Authorization/Progress Report

(Prior authorization, not to exceed 3 months, must be received prior to service being authorized and to be used for the following CCF service types: Individual Therapy, Individual AODA Therapy, Family Therapy, Group Therapy, Group AODA Therapy, Special Therapy, Specialized Offender Treatment, In-Home Treatment, Family Preservation, Day Treatment, Day Treatment-AODA, Transitional Day Treatment, and Occupational Therapy)

Check One:	<input type="checkbox"/> Initial PA Request (date range requested, 1-3 months)	<input type="checkbox"/> Reauthorization (date range requested, 1-3 months):	
Provider/Agency Name:			CCF Service Type Requested (see above):
Client Name:		Date of Birth:	Units Requesting: <input type="checkbox"/> Week <input type="checkbox"/> Month
CCF Coordinator:			
Date of last communication with coordinator:			
Are there barriers preventing progress toward goals (ex. missed appointments, transportation, etc.)?:			

Therapy Goal(s) for this authorization period <small>(please check how long this goal has been addressed in therapy)</small>	Intervention <small>Treatment Modality (Individual, family, group, insight, play, experiential, etc.)</small>	Progress (list progress for reauthorization request only) <small>(please include observable strengths during this authorization period and how cultural considerations are being incorporated into the treatment process) Please use the back of this form if more space is needed</small>
1. <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> over 12 months	_____ _____ _____	_____ _____ _____
2. <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> over 12 months	_____ _____ _____	_____ _____ _____
3. <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> 6-12 months <input type="checkbox"/> over 12 months	_____ _____ _____	_____ _____ _____

Provider Signature or Typed Name:	Date:
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For office use only: <input type="checkbox"/> PA/PR approved for the following time period _____	Rev. 01//01/2016 <input type="checkbox"/> PA/PR denied due to _____
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Additional Progress

(please include observable strengths during this authorization period and how cultural considerations are being incorporated into the treatment process)

Please use the back of this form if more space is needed

Goal 1

Goal 2

Goal 3