**Children Come First - RISE**

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

**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,

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

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| **Therapy Goal(s) for this authorization period**  (please check how long this goal has been addressed in therapy) | **Intervention**  Treatment Modality (Individual, family, group, insight, play, experiential, etc.) | **Progress (list progress for reauthorization request only)**  (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** | |
|  |  |  | |
| 0-3 months  3-6 months  6-12 months  over 12 months |
|  |  |  | |
| 0-3 months  3-6 months  6-12 months  over 12 months |
|  |  |  | |
| 0-3 months  3-6 months  6-12 months  over 12 months |
| Provider Signature or Typed Name: | | | Date: |

|  |
| --- |
| **For office use only**:  PA/PR approved for the following time period   PA/PR denied due to |

|  |  |
| --- | --- |
|  | **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** |  |

Rev. 7/2020