JUSTIFICATION FOR MENTAL HEALTH SERVICES

- ❑ **Medi-Cal Patient: Patient requires more than 2 visits per month**
  Complete form and file in chart
- ❑ **Any patient: Patient requires more than 12 visits per year**
  Complete justification form and route to PCP

PROVIDER:
Name:_____License #:_____

CLIENT:
Patient's Name: _____ Date of Birth: _____
Parent/Guardian: _____ Phone Number: _____

DIAGNOSIS:_____
_____
_____
Clinical significance of diagnosis and impact on client's daily functioning: _____
_____
_____
_____

SUMMARY OF PREVIOUS & CURRENT TREATMENTS (incl. outcomes, meds):_____
_____
_____
_____
OTHER AGENCIES/PROVIDERS: _____
_____
_____

JUSTIFICATION: _____
_____
_____
_____

TREATMENT PLAN:
Therapeutic Objectives: _____
_____
_____
Planned Therapeutic Interventions:
Quantity: _____ visit(s) per month for _____ months.

Estimated Time Frames: _____
Case reviewed during case conference? ❑ Yes ❑ No

COUNSELOR:
Signature:_____ Date: _____
PCP:
❑ Additional visits approved (list number) _____
❑ Additional visits denied (list reason_____

Signature: _____ Routing: ❑ Original to Client's Chart ❑ Copy to: _____
MEDICAL RECORD #: _____