

**Gambling Case Management Program**
REQUEST FOR CLIENT AUTHORIZATION

Choose a box below to indicate whether this form is an Initial Authorization or a Time Extension.

- INITIAL
- TIME PERIOD EXTENSION

SECTION 1. PROVIDER INFORMATION

Provider Name: _____

SAP Vendor No. _____ Contract No: _____

SECTION 2. CLIENT INFORMATION

Client ID No.: _____ Admission Date: _____ Gender: Man Woman

Is Client insured? Yes No Other _____

Does Provider participate with client's insurance? Yes No _____

If "Yes" to the above, reason for requesting authorization: If "No" to the above, reason for requesting authorization:

Client needs help with copay/ deductible No available in-network provider

Insurance does not cover Gambling/ Gaming disorder Other _____

Other _____

***Insurance denials must be received prior to submitting this request to DDAP. A verbal denial can be documented within the file if a written denial is not immediately available. A written denial must be kept in the client file once received.**

If the client needs translation services please fill out the following information

What type of translation services will you be using for this client? Cost of translation services per session:

On-site Translator \$ _____

Telephone or Video Translation Language to be interpreted: _____

Other: _____

SECTION 3. TIME PERIOD EXTENSION

If time period extension is being requested please explain the reasoning behind the request:

PROVIDER SIGNATURE/ DATE (REQUIRED)_____
Case Manager (Print)_____
Signature_____
Date**DEPARTMENT OF DRUG & ALCOHOL PROGRAMS USE ONLY**Case Management sessions will
be authorized in 6 month
intervalsAuthorization
Starts On: _____Authorization
Expires On: __________
DDAP Authorized Signature_____
Approval Date_____
DDAP Authorized Signature_____
Approval Date