Washington State Department of Social & Health Services
CA Children's Administration

ADOPTION SUPPORT PROGRAM

Preauthorization For Services

SECTION I: TO BE COMPLETED BY THE ADOPTIVE PARENT(S) (PLEASE PRINT)

LEGAL NAME OF CHILD (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH

PARENT(S) NAME	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP CODE

SERVICE REQUEST INFORMATION: TYPE OF SERVICE REQUESTED	TO BE PROVIDED BY: PROVIDER'S NAME

FAMILY INSURANCE CARRIER #1		FAMILY INSURANCE CARRIER #2	
COMPANY NAME	POLICY NUMBER	COMPANY NAME	POLICY NUMBER
ADDRESS		ADDRESS	

Will family insurance cover the above requested service? ☐ Yes ☐ No If yes, how much: _____

I am requesting service per above for my (our) child.

ADOPTIVE PARENT'S SIGNATURE	DATE	ADOPTIVE PARENT'S SIGNATURE	DATE

SECTION II: TO BE COMPLETED BY THE PROVIDER

The above named child is seeking service from you for: ☐ Counseling ☐ Medical ☐ Other (specify: _____)

Complete the following to facilitate the authorization of the service or you may attach an assessment/report describing the condition and services to be provided. Unless preauthorized by exception with the program manager, fees will be paid at medical rates. ☐ **Report attached**

DIAGNOSIS OF CHILD'S CONDITION

SERVICE BEGIN DATE	Service will be a total of _____ sessions. $_____/hour
	OR
SERVICE END DATE	The total fee for the service is $_____

BILLING INSTRUCTIONS: When applicable, the insurance company must be billed first. When submitting billings, show the amount the insurance has either paid or denied. An insurance explanation of benefits should accompany the billing. If this is a Medicaid covered service, it must be submitted to Medicaid for payment. Non-Medicaid services must be pre-authorized by an Adoption Support Program Manager on this form before initiating services. You may call toll free, 1-800-562-5682, with questions. Billings for non-Medicaid covered services are to be submitted to: DEPARTMENT OF SOCIAL AND HEALTH SERVICES, ADOPTION SUPPORT PROGRAM

PROVIDER'S SIGNATURE	CREDENTIALS
PROVIDER'S PRINTED NAME	PROVIDER'S TELEPHONE NUMBER
ADDRESS CITY STATE ZIP CODE	PROVIDER'S TAX IDENTIFICATION

SECTION III: TO BE COMPLETED BY THE PROGRAM MANAGER

1. Child is on:
   ☐ Adoption Support Program OR ☐ Reconsideration Program
2. Has medical insurance been utilized? Yes ☐ ☐ No
3. Is the requested treatment covered by Medicaid? Yes ☐ ☐ No
4. Have other available resources been utilized? Yes ☐ ☐ No
5. **Requested service approved:** Yes ☐ ☐ No

COMMENTS

PROGRAM MANAGER'S SIGNATURE	SERVICE END DATE

Route all copies of completed form to Adoption Support Program. ASP will return a copy to provider and to adoptive family.

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