215 West 4th Street Suite 6
Spencer, IA 51301
ph: 712-264-3945 • fax: 712-262-9206

EMAIL: intake@ccnia.org

SERVICE AUTHORIZATION REQUEST

Individual Name:_____**DOB**:_____

Diagnosis (DSM-IV): _____

CCNIA Application Completed: YES ☐ **NO** ☐

Quantity (units)	CPT / COA CODE	Service Requested	Rate	Dates of Service
		Initial Therapy Intake		
		Medication Management ARNP ☐ MD ☐		
		Outpatient Therapy		
		Group Therapy		
		Psychiatric Evaluation ARNP ☐ MD ☐		
		Residential Care Facility		
		Supported Community Living		
		Supportive Employment		
		Respite Individual ☐ Group ☐		
		Other Service: (Please explain below)		

Provider Name:_____**Date**: _____
Email:_____**Phone**:_____

Additional Information: