



777 Woodward Avenue.  
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Detroit, MI 48226  
Fax: 313-463-5262

Agency Name: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

### MIHP AUTHORIZATION FORM

Members Name: \_\_\_\_\_ Member ID: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Requested by: \_\_\_\_\_

Member Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Start of Care Assessment Date: \_\_\_\_\_ Circle one: Assessment in home or office

Is this a reauthorization? Yes \_\_\_\_\_ No \_\_\_\_\_

**If Yes:**

1) Initial Assessment Date \_\_\_\_\_

2) Dates of all Previous Visits

\_\_\_\_\_  
\_\_\_\_\_

3) Issues or condition affecting the individual's need for reauthorizations:

\_\_\_\_\_

4) Number of Additional Visits Requested \_\_\_\_\_

**If MSS:**

EDC Date: \_\_\_\_\_

OB Dr: \_\_\_\_\_

**Comments:**

\_\_\_\_\_  
\_\_\_\_\_

All visits should be completed before requesting additional visits. Reauthorizations request should accompany supporting documentation. Thank you for your cooperation.