

REQUEST FOR INITIAL LEVEL OF CARE AUTHORIZATION

Instructions: This is an interactive form. Please complete all form fields, save the document and email this document to info@hughencenter.org or fax to 409-983-6408.

TO:

**The Hughen Center, Inc.
2849 Ninth Avenue
Port Arthur, Texas 77642**

(817)

FROM CONTRACTOR:

Name		
Telephone No.	FAX No.	
Address		
City	State	Zip

Date of Placement with Contractor:		Child's Name:	
Date of Birth:		Person ID:	Medical No.:
Ethnicity:	Sex:	County of Conservatorship:	Region:

REQUEST FOR INITIAL AUTHORIZATION – Attachments:

- Contractor Common Application, form 2087c
- Most recent psychological / psychiatric report
- Information on medical problems or disabilities
- Description of any extenuating circumstances, or incidents

REQUEST FOR RECONSIDERATION AFTER DENIAL – Attached is add'l information necessary for accurate determination.

CASEWORKER INFORMATION:

Name	
Telephone No.	FAX No.
City	Mail Code

Signature – Clinical Director*

Date

**Signature required at time of placement.*