



## Outpatient Treatment Continuation Form (MDs Only)

Requestor's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

Clinician's Name: \_\_\_\_\_

Clinician NPI #: \_\_\_\_\_ Group NPI #: \_\_\_\_\_

Address Where Services will be Rendered:

\_\_\_\_\_

**Patient Name:** \_\_\_\_\_

**ID Card #:** \_\_\_\_\_ **Diagnosis: Axis I** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **Axis II** \_\_\_\_\_

**CPT Code Requested:** \_\_\_\_\_ **Date of Last Visit:** \_\_\_\_\_

**What is the frequency at which the patient is being seen?** \_\_\_\_\_

**What is the date you want this certification to start?** \_\_\_\_\_

\_\_\_\_\_  
**Signature**
**Date**

**\*\*\*\*Contact with the prescribing or referring physician is strongly recommended.**

Date of Contact: \_\_\_\_\_ Method of Contact:  Telephone  Fax  Progress Note

**Please make additional copies of this form for your office use. Thank you.**