Permanent Change of Treatment Authorization for TERM Group Facilitator

Fax form to Optum TERM at 877-624-8376

Notify current PSW of change prior to rendering services to TERM-referred clients

- The new group facilitator must be TERM-approved for the relevant clinical specialties prior to rendering services
- The new group facilitator must be available for consultation with the PSW or Court about the services they provided
- This change in group facilitator is for the ***current episode of care only*****.** A new intake assessment will **not** be authorized; however, if the change in providers is being made prior to completion of the intake session please contact TERM at 877-824-8376 Option 1 to request authorization of an intake session for the new group facilitator.
- The newly assigned facilitator must have their change of treatment authorization request submitted and approved prior to facilitating groups for TERM-referred clients. CFWB Payment Authorization Requests coordinated through the PSW will be required for retroactive changes.
- The new group facilitator will be expected to submit quarterly reports by due date (when applicable).
- Authorizations will be entered for future dates only. A 3-month authorization period for both group services and reports will be entered effective the date requested (future dates only) or the date the request was approved. (*Provider will be notified of Incomplete and/or Unprocessed requests within 5 days of submission.)*
    - ***Expired Authorizations*** - If the current authorization on file is expired, the request will not be processed and the PSW will need to submit a Payment Authorization Request to backdate authorization and change facilitator.
    - ***Termination of Service*** - *Requests made for* Cases that have been terminated by CFWB or the Court will not be processed.
- The previous group facilitator's authorization *will be ended* one day prior to the effective date of the new facilitator's authorization.

Client Information

Client Name: _____

Case #: _____ **DOB**: _____

Type of Treatment

Group: Domestic Violence Victim ☐ Domestic Violence Offender ☐ Child Abuse ☐

Child Sexual Abuse NPP ☐ Child Sexual Abuse Offender ☐

Provider Information

Provider of Record: _____
(Please Print & Include Licensure)

_____
(Signature)

New Provider: _____
(Please Print & Include Licensure)

_____
(Signature)

Supervisor Signature: _____
(If either providers above are Interns, signature of Supervising TERM Provider is required.)

Reason for Change:

Effective date of change: Date: _____

Name and contact # of PSW (please print): _____

Date PSW was notified of Change of Provider Request: _____