VALUEOPTIONS®
COLORADO PARTNERSHIPS

SUD Service
Re-authorization Request

Instructions: All fields are **required**. **Include this form with the Treatment Plan and Initial Assessment** for each member.
Submit **one form for each member**! **FAX only ONE member at a time**, do not send multiple members in one fax submission.
Your request will be processed within 10 days of our receipt. We only retro authorize 30 days from the date of receipt.

Member Name and DOB	
Medicaid ID#	
Provider Name & ID# (VO Assigned ID# from Prov. Rel.)	
Provider Phone # and Fax #	
Current SUD Diagnoses	

Initial Treatment Start Date		Estimated Discharge Date	

Substance Use Update: since admission to THIS episode of treatment	☐ Client has maintained sobriety since entering treatment. ☐ Client has relapsed. Include usage information below:
Substance Used:	Substance Used:
Last Use:	Last Use:

Current Risk Factors	Mental Health Concerns: Medical Problems: Employment Problems: Legal Involvement: Housing Issues:
Treatment Update	Describe client engagement in treatment and progress towards client's treatment goals.
Justification for Continued Treatment	How do the client's symptoms, behaviors and relapse risks indicate a need for ongoing treatment

Current Request for Authorization:	Service Code (CPT)	Units Requested (For 6 months period)	Frequency (Monthly, weekly, etc.)	Length of Session (Minutes)

Return form to: ValueOptions – Colorado, Attn: CSA's/Member Service
Fax: 719-538-1439 Phone: 800-804-5008