

REQUEST FOR RETRO-AUTHORIZATION

VBH-Clinical Director
520 Pleasant Valley Road
Trafford PA 15085
Fax: 724-744-6329

Dear Clinical Director:

Please consider this request for a retro-authorization for the following member:

Provider Name: _____ Provider ID# _____

Provider Address: _____

Phone #: _____ Fax# _____

Contact Person: _____

Member's Name: _____

Member's ID #: _____

DOB: _____ SS # _____

Diagnosis _____ M/H _____ D/A _____

Explanation for Retro-authorization:

Service Class Requested	Start Date	End Date	Units

Thank you for your attention and consideration to this request.

Signature
Revised 08/06/08

Date