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| State_Seal3 | DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)  **Adoptive Parent Counseling**  **Preauthorization For Services** | | | | | | | |
| **Section I: To be completed by the adoptive parent(s) (please print)** | | | | | | | | |
| LEGAL NAME OF CHILD ON PROGRAM (LAST, FIRST, MIDDLE) | | | | | | | DATE OF BIRTH | |
| PARENT(S) NAME | | | | | HOME TELEPHONE NUMBER | | WORK TELEPHONE NUMBER | |
| ADDRESS CITY STATE ZIP CODE | | | | | | | | |
| SERVICE REQUEST INFORMATION: TYPE OF SERVICE REQUESTED **Adoptive Parent Counseling** | | | | | TO BE PROVIDED BY: PROVIDER’S NAME | | | |
| FAMILY INSURANCE CARRIER 1 | | | | | FAMILY INSURANCE CARRIER 2 | | | |
| COMPANY NAME | | | | POLICY NUMBER | COMPANY NAME | | | POLICY NUMBER |
| ADDRESS | | | | | ADDRESS | | | |
| Will family insurance cover the above requested service?  Yes  No If yes, how much:  **I am requesting service as a parent.** | | | | | | | | |
| ADOPTIVE PARENT’S SIGNATURE | | | DATE | | ADOPTIVE PARENT’S SIGNATURE | | | DATE |
| **Section II: To be completed by the provider (please print)** | | | | | | | | |
| Adoptive Parent Counseling: | | | | | | | | |
| SERVICE BEGIN DATE | | Service will be a total of  sessions. $/ hour  OR  The total fee for the service is $ | | | | | | |
| SERVICE END DATE | |
| BILLING INSTRUCTIONS When applicable, the insurance company must be billed first. When submitting billings, show the amount the insurance has either paid or denied. An insurance explanation of benefits should accompany the billing. Non-Medicaid services must be pre-authorized by an Adoption Support Program Manager on this form and a service referral before initiating services. Billings for non-Medicaid covered services are to be emailed to: [ASProfessionalSvcs@dcyf.wa.gov](mailto:ASProfessionalSvcs@dcyf.wa.gov), or mail to Payment Integrity Unit, P.O. Box 45710, Olympia, WA 98504. | | | | | | | | |
| PROVIDER’S SIGNATURE | | | | | | CREDENTIALS | | |
| PROVIDER’S PRINTED NAME | | | | | | PROVIDER’S TELEPHONE NUMBER | | |
| ADDRESS CITY STATE ZIP CODE | | | | | | PROVIDER’S TAX IDENTIFICATION | | |
| **Section III: To be completed by the program manager (please print)** | | | | | | | | |
| YES NO  1.  Adoption Support Program  2. Has medical insurance been utilized?  3. Have other available resources been utilized?  4. **Requested service approved** | | | | | COMMENTS | | | |
| PROGRAM MANAGER’S SIGNATURE | | | SERVICE END DATE |

**Route all copies of completed form to Adoption Support Program.**

**ASP will return copies to provider and adoptive family**