DDAP-EFM-1320 Rev. 7-23

pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Gambling Treatment Program

REQUEST FOR CLIENT AUTHORIZATION

One Penn Center, 5th Floor
2601 N. 3rd Street
Harrisburg, PA 17110
Ph: 717-783-8200
Fax: 717-787-6285
RA-DA_GAMBLING@pa.gov

Choose a box below to Indicate whether this form is an Initial Authorization, an Extension, or an Additional Client Session request.

☐ **INITIAL**

☐ **TIME PERIOD EXTENSION/ ADDITIONAL CLIENT SESSIONS**

SECTION 1. PROVIDER INFORMATION

Provider Name: _____

SAP Vendor No. _____ Contract No: _____

SECTION 2. CLIENT INFORMATION

Client ID No.: _____ Admission Date: _____ Gender: ☐ Male ☐ Female ☐ Other _____

Is Client insured? ☐ Yes ☐ No

Does Provider participate with client's insurance? ☐ Yes ☐ No

If "Yes", reason for requesting authorization:

- ☐ Client needs help with copay/ deductible
- ☐ Insurance does not cover Gambling/ Gaming disorder
- ☐ Other _____

If "No", reason for requesting authorization:

- ☐ No available in-network provider
- ☐ Insurance does not cover Gambling/ Gaming disorder
- ☐ Other _____

*Insurances denials require verbal denial before submitting and a written denial must be kept in the client record

SECTION 3. TIME PERIOD EXTENSION/ ADDITIONAL CLIENT SESSIONS

If time period extension or additional sessions are being requested please explain the reasoning behind the request:

PROVIDER SIGNATURE/ DATE (REQUIRED)

Certified Gambling Counselor (Print)	Signature	Date

DEPARTMENT OF DRUG & ALCOHOL PROGRAMS USE ONLY

No. of Sessions Authorized: _____ Authorization Starts On: _____ Authorization Expires On: _____

DDAP Authorized Signature _____ Approval Date _____

DDAP Authorized Signature _____ Approval Date _____