**UNITED THERAPEUTIC SERVICES LLC**

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| Service Authorization Form |  | Case#:Case Manager:CM Phone:CM Email: | Service Type: County: |
| Client’s Name: Client’s DOB:Client’s Address: |  |
| Authorization Period: \_\_/\_\_/\_\_ to \_\_/\_\_/\_\_  | Total  | ## of Hours Authorized:  |
|   |
|  |  | Description of Services Requested |
|   |  |
| **Additional Comments:****(Please include all other pertinent case details)** |  |
| Authorized Signatures |  |
| Name of person making referral: | Signature: |
| Date: |
| **For Office Use Only****Date Received: Approved: Y N**  | Reviewed By:Assigned Staff: |