**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: | |