Irish Life health

Request for preauthorisation of additional sessions with Centric Mental Health

Clinician Details

Requesting Clinician	
Email	

Patient Details

CMH Patient ID	

To be Completed by the Requesting Consultant Please confirm the following:

Number of sessions the Member has completed to date for the present referral	
Member is suitable to continue their treatment with Centric Mental Health and does not require more specialised interventions	Yes ◯ No ◯
As the clinician I believe the member will benefit from additional sessions	Yes ◯ No ◯
How many additional sessions would you like to request	
Has the member had any additional sessions to date in advance of the preauth being submitted ?	Yes ◯ No ◯
If yes, how many additional sessions have they had?	

Declaration

I hereby confirm that the preapproval for additional sessions with Centric Mental Health is being sought as an integral part of treatment and that the member has agreed to this treatment.

I/we confirm that all the details, answers and information given in this form are true, accurate and complete.

Clinicians name in block capitals:	
Clinician signature:	
IMC registration number:	
Date: (dd/mm/yy)	