



## Benefit Conversion Justification Request

Enrollee Name: \_\_\_\_\_ ID#: \_\_\_\_\_

Provider: \_\_\_\_\_ Benefit Year: \_\_\_\_\_

**(Please print or write legibly)**

1. Please document why you believe enrollee is at risk of retrogression without continuing outpatient services:

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2. Please document your therapeutic interventions to date and why you feel the enrollee has not been stabilized within the plan's allotted number of outpatient sessions:

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3. Will you be changing your therapeutic interventions? \_\_\_\_ Yes \_\_\_\_ No  
Please Explain:

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4. Please document your strategy for managing within the benefit in the future:

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5. Number of additional sessions requested: \_\_\_\_\_ per month X \_\_\_\_\_ months.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_