Santa Barbara County Department of Behavioral Wellness

SB-163 Initial Authorization Request

Please **TYPE**, fill out completely, and attach required documents.

Submit request and documents to: BWELLQCM@SBCBWELL.org

Please allow up to 5 business days for the request to be processed

Date of Authorization Request:
Client Information
Client Name:
Client ID:
DOB:
Provider Information
SB-163 Assessor Name:
Phone Number:
Email Address:
Service Number of Comprehensive Assessment:
Service Number of Treatment Plan:
Service Authorization Information
Please include: WIT referral Medi-Cal eligibility
✓ Please ensure client's assessment and treatment plan is complete and finalized in Clinician's Gateway.

For Quality Assurance Use Only
Authorization Information:
Approved:
If no, provide reason denied:

Authorization Date:	Authorization Expiration Date:
QCM Coordinator Signature:	