SUBMIT TO
Utilization Management Department
PHONE 1.844.366.2880 | FAX 1.855.868.4940

silversummit healthplan

NONPAR OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date _____

MEMBER INFORMATION

First Name _____

Last Name _____

DOB _____

Member ID # _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID # _____

Provider/Agency NPI Sub Provider # _____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary (Required) _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with PCP? ☐ Yes ☐ No

Date first seen by provider/agency _____

Date last seen by provider/agency _____

SPMI/SED ☐ Yes ☐ No

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT.)

1. In the last 30 days, have you had problems with sleeping or feeling sad?	☐ Yes (5)	☐ No (0)
2. In the last 30 days, have you had problems with fears and anxiety?	☐ Yes (5)	☐ No (0)
3. Do you currently take mental health medicines as prescribed by your doctor?	☐ Yes (0)	☐ No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you?	☐ Yes (5)	☐ No (0)
5. In the last 30 days, have you gotten in trouble with the law?	☐ Yes (5)	☐ No (0)
6. In the last 30 days, have you actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?	☐ Yes (0)	☐ No (5)
7. In the last 30 days, have you had trouble getting along with other people including family and people outside the home?	☐ Yes (5)	☐ No (0)
8. Do you feel optimistic about the future?	☐ Yes (0)	☐ No (5)
CHILDREN ONLY:		
9. In the last 30 days, has your child had trouble following rules at home or school?	☐ Yes (5)	☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCBS or DJJ)?	☐ Yes (5)	☐ No (0)
ADULTS ONLY:		
11. Are you currently employed or attending school?	☐ Yes (0)	☐ No (5)
12. In the last 30 days, have you been at risk of losing your living situation?	☐ Yes (5)	☐ No (0)

Therapeutic Approach/Evidence Based Treatment Used _____

LEVEL OF IMPROVEMENT TO DATE

☐ Minor ☐ Moderate ☐ Major ☐ No progress to date ☐ Maintenance treatment of chronic condition

Barriers to Discharge

_____

_____

Current Measurable Treatment Goals

_____

_____

_____

_____

SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Hyperactivity/Inattn.	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐
Other (include severity): _____				
Risk of OOH Placement	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐
Last Date of substance use: _____				

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐
Drug(s) of Choice _____				
Attending AA/NA	☐ Yes	☐ No		

RISK ASSESSMENT

Suicidal	☐ None	☐ Ideation	☐ Planned	☐ Imminent Intent	☐ History of self-harming behavior
Homicidal	☐ None	☐ Ideation	☐ Planned	☐ Imminent Intent	☐ History of harm to others
Safety Plan in place? (If plan or intent indicated):			☐ Yes	☐ No	
Medical Psychiatric Evaluation completed?			☐ Yes	☐ No	
If prescribed medication, is member compliant?			☐ Yes	☐ No	

REASONS FOR REQUESTING/ PROVIDING SERVICES OUT OF NETWORK

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATED MODIFIER, IF APPLICABLE)

All out of network services require prior authorization, please indicate which codes below you are requesting

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Assessments					
Alcohol and/or drug assessment ☐ H0001					
Mental Health Screen/Intensity of Needs Determination (LOCUS/CASII) ☐ H0002					
Comprehensive Assessment/Mental health assessment by non-physician ☐ H0031					
Alcohol/drug screening ☐ H0049					
Psychiatric/Psychological Evaluation/ Psychiatric Diagnostic Interview (MH/SA) ☐ 90791					
Psychiatric/Psychological Evaluation/ Psychiatric Diagnostic Interview (MH/SA) ☐ 90792					
Psychological Assessment/Brief emotional/ behavioral assessment ☐ 96127					
Health and Behavior Assessment, Initial ☐ 96150					
Health and Behavior Assessment, Reassessment ☐ 96151					
Alcohol screening in adults, including pregnant women/AUDIT/DAST 15-30 min ☐ 99408					
Alcohol screening in adults, including pregnant women/AUDIT/DAST > 30 min ☐ 99409					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Mental Health/Substance Abuse Therapies					
Family psychotherapy (without the patient present) (MH/SA) ☐ 90846					
Family psychotherapy (conjoint therapy) (with patient present) (MH/SA) ☐ 90847					
Multiple-family group psychotherapy (MH/SA) ☐ 90849					
Health and behavior intervention focusing on biopsychosocial factors related to the recipient's health status; family (with patient present) ☐ 96154					
Health and behavior intervention focusing on biopsychosocial factors related to the recipient's health status; family (without patient present) ☐ 96155					
Alcohol and/or drug srevices; group counseling by a clinician ☐ H0005					
Group psychotherapy (other than of a multiple-family group) (MH/SA) ☐ 90853					
Health and behavior intervention focusing on biopsychosocial factors related to the recipient's health status; group (2 or more) ☐ 96153					
Indivudial Behavioral health counseling and therapy ☐ H0004					
Alcohol and/or drug services; (State defined: individual counseling by a clinician) ☐ H0047					
Individual Psychotherapy, 30 minutes w/ patient and/or family member (MH/SA) ☐ 90832					
Individual Psychotherapy, 45 minutes w/ patient and/or family member (MH/SA) ☐ 90834					
Individual Psychotherapy, 60 minutes w/ patient and/or family member (MH/SA) ☐ 90837					
Alcohol and/or drug services; crisis intervention (outpatient) ☐ H0007					
Individual Psychotherapy for crisis; first 60 min ☐ 90839					
Individual Psychotherapy for crisis; each additional 30 min ☐ 90840					
Individual Psychotherapy, 30 minutes w/ patient and/or family member w/ e&m ☐ 90833					
Individual Psychotherapy, 45 minutes w/ patient and/or family member w/ e&m ☐ 90836					
Individual Psychotherapy, 60 minutes w/ patient and/or family member w/ e&m ☐ 90838					
Individual Office visit for e&m of a new patient; minor severity; 10 min (MH/SA) ☐ 99201					
Individual Office visit for e&m of a new patient;low to moderate severity; 20 min (MH/SA) ☐ 99202					
Individual Office visit for e&m of a new patient; moderate severity; 30 min (MH/SA) ☐ 99203					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Individual Office visit for e&m of a new patient; moderate to high severity; 45 min (MH/SA) ☐ 99204					
Individual Office visit for e&m of a new patient; moderate to high severity; 60 min (MH/SA) ☐ 99205					
Individual Office visit for e&m of an established patient; minimal severity; 5 min (MH/SA) ☐ 99211					
Individual Office visit for e&m of an established patient; minor severity; 10 min (MH/SA) ☐ 99212					
Individual Office visit for e&m of an established patient; low to moderate severity; 15 min (MH/SA) ☐ 99213					
Individual Office visit for e&m of an established patient; moderate to high severity; 25 min (MH/SA) ☐ 99214					
Individual Office visit for e&m of an established patient; moderate to high severity; 40 min (MH/SA) ☐ 99215					
Individual Health and behavior intervention focusing on biopsychosocial factors related to the recipient's health status ☐ 96152					
Neurotherapy, Individual psychophysiological therapy incorporating biofeedback; 30 minutes ☐ 90875					
Neurotherapy, Individual psychophysiological therapy incorporating biofeedback; 45 minutes ☐ 90876					
Neurotherapy, Biofeedback training any method ☐ 90901					
Neurotherapy, Biofeedback peri/uro/rectal ☐ 90911					
Neurotherapy, Functional brain mapping ☐ 96020					
Telehealth Facility Fee ☐ Q3014					
Interactive complexity ☐ 90785					
Tobacco use counseling and interventions for pregnant women, Behavior change smoking 3-10 min ☐ 99406					
Tobacco use counseling and interventions for pregnant women, Behavior change smoking > 10min ☐ 99407					
Outpatient Alcohol/SA Services, Preventive med counseling ☐ 99401					
Mental Health/Substance Abuse Therapeutic					
Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program) ☐ H0020					
Medication training and support (Mental health or substacne abuse) ☐ H0034					
Office visit for the sole purpose of monitoring or changing prescriptions used in the treatment of mental psychoneurotic and personality disorders ☐ M0064					
Therapeutic, prophylactic, or diagnostic injection ☐ 96372					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Rehabilitative Mental Health (Rhm) Services					
Crisis Intervention ☐ H2011					
Day Treatment ☐ H2012					
Basic Skills Training (BST) ☐ H2014					
Psychosocial Rehabilitation (PSR) ☐ H2017					
Peer-to-Peer Support ☐ H0038					
Program for Assertive Community Treatment (PACT) ☐ H0040					
Case Management Services					
Case management for Level I and II adults and children ☐ T1016					
Targeted Case Management ☐ T1017					
Other Specified Case Management ☐ G9012					

For applicable service requests, please include the following information and corresponding clinical documentation: LOCUS/CASII Score _____ Intensity of Needs Level _____

Have traditional behavioral health services been attempted? (e.g. individual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Additional Information?

Please attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

Clinician Printed Name

Clinician Signature

Date