SUBMIT TO
Utilization Management Department
PHONE 1.844.366.2880 | FAX 1.855.868.4940

silversummit healthplan

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	

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

All out of network services require prior authoirzation, please indicated which codes below you are requesting

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Mental Health/Substance Abuse Therapies					
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					
Neurotherapy, Individual psychophysiological therapy incorporating biofeedback; 30 minutes ☐ 90875					
Neurotherapy, Individual psychophysiological therapy incorporating biofeedback; 45 minutes ☐ 90876					
Rehabilitative Mental Health (Rmh) 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					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Case Mangement Services					
Case management for Level I and II adults and children ☐ T1016					
Targeted Case Management ☐ T1017					
Other Specified Case Management ☐ G9012					

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

Additional Information?

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

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

Clinician Printed Name

Clinician Signature

Date