

SUBMIT TO

Utilization Management Department

PHONE 1.844.366.2880 | FAX 1.855.868.4940



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		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/Inattn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (include severity): _____				
					Risk of OOH Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice _____				
Last Date of substance use: _____					Attending AA/NA	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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 MODIFIER, IF APPLICABLE)

All out of network services require prior authorization, 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) <input type="checkbox"/> H0007					
Behavioral Health Outpatient Therapy <input type="checkbox"/> 90832, 90833, 90834, 90836, 90837, 90838, 90845, 90847, 90853					
Neurotherapy, Biofeedback peri/uro/rectal <input type="checkbox"/> 90911					
Neurotherapy, Functional brain mapping <input type="checkbox"/> 96020					
Neurotherapy, Biofeedback training any method <input type="checkbox"/> 90901					
Substance Abuse Counseling <input type="checkbox"/> H0005, <input type="checkbox"/> H0047, <input type="checkbox"/> H0004					
Individual Psychotherapy for crisis; first 60 min <input type="checkbox"/> 90839					
Individual Psychotherapy for crisis; each additional 30 min <input type="checkbox"/> 90840					
Neurotherapy, Individual psychophysiological therapy incorporating biofeedback; 30 minutes <input type="checkbox"/> 90875					
Neurotherapy, Individual psychophysiological therapy incorporating biofeedback; 45 minutes <input type="checkbox"/> 90876					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Rehabilitative Mental Health (Rmh) Services					
Crisis Intervention <input type="checkbox"/> H2011					
Day Treatment <input type="checkbox"/> H2012					
Basic Skills Training (BST) <input type="checkbox"/> H2014					
Psychosocial Rehabilitation (PSR) <input type="checkbox"/> H2017					
Peer-to-Peer Support <input type="checkbox"/> H0038					
Program for Assertive Community Treatment (PACT) <input type="checkbox"/> H0040					
Other					
Service Requested: <input type="checkbox"/> _____					

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?

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