

SUBMIT TO
Utilization Management Department
 Phone: 1-855-766-1497 Fax: 1-877-725-7751



OUTPATIENT TREATMENT REQUEST FORM

Date: _____

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

MEMBER INFORMATION

Name: _____
 Date of Birth: _____
 Member ID #: _____

PROVIDER INFORMATION

Provider Name (print): _____
 Provider/Agency Tax ID #: _____
 Provider/Agency NPI Sub Provider #: _____
 Phone #: _____ Fax #: _____

CURRENT ICD DIAGNOSIS

*Primary: _____
 Secondary: _____
 Tertiary: _____
 Additional : _____
 Additional: _____

Has contact occurred with PCP? Yes No

Date first seen by provider/agency: _____

Date last seen by provider/agency: _____

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 out the home?
 Yes (5) No (0)
8. Do you feel optimistic about the future? Yes (0) No (5)
9. Are you currently employed or attending school? Yes (0) No (5)
10. 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:

SYMPTOMS

	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/Inattention	<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): _____				

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 Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice: _____				

Last Date of Substance Use: _____

RISK ASSESSMENT

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

CURRENT MEASUREABLE TREATMENT GOALS

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

Service	Date Service Started	Frequency: How Often Seen	Intensity: Number Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
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IF YOU ARE A NON PARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR: OTHER CODE(S) REQUESTED:

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?

STANDARD REVIEW:
Standard 14-day time frame will be applied.

EXPEDITED REVIEW: By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life, or ability to regain maximum function.

Clinician Signature Date

Clinician Signature Date

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

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