absolute total care | Healthy Connections

SUBMIT TO
Utilization Management Department
PHONE 1-866-433-6041 FAX 1-866-694-3649

OUTPATIENT TREATMENT REQUEST FORM

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

MEMBER INFORMATION

Date

Name

Date of Birth

Member ID #

PROVIDER INFORMATION

Provider Name

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/your child had problems with sleeping or feeling sad?	☐ Yes (5)	☐ No (0)
2. In the last 30 days, have you/your child had problems with fears and anxiety?	☐ Yes (5)	☐ No (0)
3. Do you/your child 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 or your child?	☐ Yes (5)	☐ No (0)
5. In the last 30 days, have you/your child gotten in trouble with the law?	☐ Yes (5)	☐ No (0)
6. In the last 30 days, have you/your child 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/your child had trouble getting along with other people including family and people outside the home?	☐ Yes (5)	☐ No (0)
8. Do you/your child 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 (DCF criminal justice)?	☐ 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

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/Inattention	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐

Other (include severity): _____

_____ Member Name

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

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐

Last Date of Substance Use: _____

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐

Drug(s) of Choice: _____

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 MEASURABLE TREATMENT GOALS

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

SERVICE	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # UNITS PER VISIT	REQUESTED START DATE FOR THIS AUTH	ANTICIPATED COMPLETION OF SERVICE
Licensed Independent Practitioners (LIPs)				
☐ Behavioral Health Screening (H0002) (15 min. units)				
☐ Diagnostic Assessment - Initial (H2000) (encounter)				
☐ Diagnostic Assessment - Follow Up (H0031) (encounter)				
☐ Individual Therapy (30 min. units)				
☐ Family Therapy (30 min. units)				
☐ Group Therapy (30 min. units)				
☐ Team Conference (99366, 99367) (15 min. units)				
MD or Nurse Practitioner				
☐ Individual Therapy				
☐ Family Therapy				
☐ Group Therapy				
☐ Medication Management				
☐ Environmental Intervention (90882)				
☐ Interpretation of Results (90887)				
FQHC / RHC				
☐ Health/Behavioral Assessment (96150)				
☐ Health/Behavioral Re-assessment (96151)				
☐ Health Intervention, individual (96152)				
☐ Health Intervention, group (96153)				
☐ Health Intervention, family (96154)				
☐ Inclusive Clinic Visit (T1015 HE) (encounter)				
RBHS				
☐ Individual Therapy - (Please Indicate Code)				
☐ Family Support- S9482				
☐ Behavioral Modification/ Skills Training and Develoment-H2014				
☐ Psychosocial Rehabilitation Services - H2017				
☐ Community Integration Services - H2030				
☐ Peer Support - H0038				
☐ Therapeutic Child Care- H2037				

IF YOU ARE A NONPARTICIPATING 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?

Provider Name Date

Provider Signature Date

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