

SUBMIT TO

Utilization Management Department

PHONE 1-866-595-8133 | FAX 1-888-725-0101



OUTPATIENT TREATMENT REQUEST FORM

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

Date _____

MEMBER INFORMATION

Name _____

DOB _____

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/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 (0) No (5)
- 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 out 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 the rules at home or school? Yes (0) No (5)
- 10. In the last 30 days, has your child been placed in state custody (DCFS or Juvenile Justice)? Yes (5) No (0)

ADULTS ONLY

- 11. Are you currently employed or attending school? _____ Yes (5) No (0)
- 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		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):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTIONAL IMPAIRMENT (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: _____									

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
 If prescribed medication, is member compliant? Yes No

CURRENT MEASURABLE TREATMENT GOALS

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

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # OF UNITS PER VISIT	REQUESTED START DATE FOR AUTH	ANTICIPATED COMPLETION: DATE OF SERVICE
--	----------------------	---------------------------	---------------------------------	-------------------------------	---

ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING

Behavioral Health Outpatient Services (billed with CPT Codes) <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Family Therapy					
Alcohol and/or Drug Services <input type="checkbox"/> H0011 <input type="checkbox"/> H0012 <input type="checkbox"/> H0014					
Respite Care (No authorization requirement for 7 days After 7 days, authorization is required) <input type="checkbox"/> H0045 HA <input type="checkbox"/> S9125					
Community Psychiatric Support Treatment <input type="checkbox"/> H0036 HO/HN/HM <input type="checkbox"/> H0036 HO/HN (Homebuilders) <input type="checkbox"/> H0036 HE Functional Family Therapy (FFT)					
Assertive Community Treatment Program (ACT) <input type="checkbox"/> H0039					
Psychiatric Health Facility Service, per diem <input type="checkbox"/> H2013					
Psychosocial Rehabilitative Services <input type="checkbox"/> H2017 Individual Office <input type="checkbox"/> H2017 HA/HQ child/adolescent program, office group <input type="checkbox"/> H2017 HA/HQ child/adolescent program, group place of service. 11 or 53 for home and community <input type="checkbox"/> H2017 HB/HQ adult program, non-geriatric, office group <input type="checkbox"/> H2017 HB/HQ adult program, non-geriatric group place of service. 11 or 53 for home and community. <input type="checkbox"/> H2017 TG (PSR) <input type="checkbox"/> H2017 TG/U8 (PSR)					
Foster Care, Therapeutic, Child, per diem <input type="checkbox"/> S5145					

PRIOR AUTHORIZATION FOR PSYCHOTHERAPY CODES (EXCESS OF 12 SESSIONS IN A CALENDAR YEAR BY A SINGLE PROVIDER)

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	AUTH BY SERVICES: # OF VISITS	REQUESTED START DATE FOR AUTH	ANTICIPATED COMPLETION: DATE OF SERVICE
<input type="checkbox"/> 90832 Psychotherapy 30 min. with patient and/or family member					
<input type="checkbox"/> 90833* Psychotherapy 30 min. with patient and/or family member when performed with an E/M service					
<input type="checkbox"/> 90834 Psychotherapy 45 min. with patient and/or family member					
<input type="checkbox"/> 90836* Psychotherapy 45 min. with patient and/or family member when performed with an E/M service					
<input type="checkbox"/> 90837 Psychotherapy 60 min. with patient and/or family member					
<input type="checkbox"/> 90838* Psychotherapy 60 min. with patient and/or family member when performed with an E/M service					
<input type="checkbox"/> 90840 Psychotherapy for Crisis each additional 30 min.					
<input type="checkbox"/> 90847 Family Psychotherapy conjoint psychotherapy; with patient present					
<input type="checkbox"/> 90849 Multiple Family Group Psychotherapy					
<input type="checkbox"/> 90853 Group Psychotherapy other than of a multiple family group					
<input type="checkbox"/> 90845 Psychoanalysis					
<input type="checkbox"/> 90875 Individual Therapy with Biofeedback 30 min.					
<input type="checkbox"/> 90876 Individual Therapy with Biofeedback 60 min.					

* If this add-on code is billed with any other service, that visit will count towards the 12 visits.

Are you requesting beyond the recommended guidelines of the HCBS? If so, please provide a brief justification or rationale for the increase in requested units.

If this is a re-authorization, please provide a brief narrative expressing the success or lack of success during the previous authorization period. Describe what worked for the member, what did not work for the member, and what will be different moving forward.

