SUBMIT TO
Utilization Management Department
Phone: 1-800-222-9831 Fax: 1-877-725-7751

allwell. FROM mhs health wisconsin

OUTPATIENT TREATMENT REQUEST FORM

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

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

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 progressto date ☐ Maintenance treatment of chronic condition

Barriers to Discharge

SYMPTOMS

	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):_____

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS

	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:_____

Member Name _____

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

Service	Date Service Started	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service

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.

Clinician Signature Date

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

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

SUBMIT TO
Utilization Management Department
Phone: 1-800-222-9831 Fax: 1-877-725-7751