

## 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/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 out 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 the 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

	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): _____				

### 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: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
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**BEHAVIORAL HEALTH OUTPATIENT SERVICES**

Alcohol & Drug Abuse Services Families and Couples <input type="checkbox"/> T1006(1 hour units)					
Alcohol & Drug Intervention Services <input type="checkbox"/> H0022(1 hour units)					
Behavioral Health Outpatient Services (billed with CPT codes): <input type="checkbox"/> Individual  <input type="checkbox"/> Group Therapy  <input type="checkbox"/> Family Therapy					

**IF YOU ARE A NON PARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR:**

**OTHER CODE(S) REQUESTED:**

<input type="checkbox"/>					
<input type="checkbox"/>					
<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?

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

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

SUBMIT TO  
**Utilization Management Department**  
 Phone: 800-589-3186 FAX 1.866.694.3649