SUBMIT TO
Utilization Management Department
PHONE 1.844.385.2192 | FAX 1.866.593.1955

OUTPATIENT TREATMENT REQUEST FORM

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

Date _____

MEMBER INFORMATION

First Name _____

Last Name _____

DOB _____

Member ID # _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID # _____

Provider/Agency NPI Sub Provider # _____

Phone _____ Fax _____

CURRENT ICD-10 DIAGNOSIS

Primary (Required) _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with PCP? ☐ Yes ☐ No

Date first seen by provider/agency _____

Date last seen by provider/agency _____

SPMI/SED ☐ Yes ☐ No

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 outside 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 rules at home or school?	☐ Yes (5)	☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCBS or DJJ)?	☐ 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

_____

Current Measurable Treatment Goals

_____

_____

_____

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/Inattn.	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐
Other (include severity): _____				
Risk of OOH Placement	☐	☐	☐	☐

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

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐
Last Date of substance use: _____				

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐
Drug(s) of Choice _____				
Attending AA/NA	☐ Yes	☐ No		

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	
Medical Psychiatric Evaluation completed?			☐ Yes	☐ No	
If prescribed medication, is member compliant?			☐ Yes	☐ No	

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATED MODIFER, IF APPLICABLE)

All out of network services require prior authoirzation, please indicated which codes below you are requesting

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Individual Psychotherapy ☐ 90832- 30 min. ☐ 90833- 30 min. ☐ 90834- 45 min. ☐ 90836- 45 min. ☐ 90837- 60 min. ☐ 90838- 60 min.					
Individual Psychotherapy- Crisis ☐ 90939- 1st hour ☐ 90840- additional 30 min.					
Group Psychotherapy ☐ 90853					
Family Psychotherapy ☐ 90846- without identified client present ☐ 90847- with identified client present **Child- Parent Psychotherapy** ☐ 90847 **Parent-Child Interaction Therapy (PCIT)** ☐ 90847					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Functional Family Therapy ☐ 90832- 30 min. ☐ 90834- 45 min. ☐ 90837- 60 min. ☐ 90846- without identified client present ☐ 90847- with identified client present					
Multisystemic Therapy ☐ H2033					
Adult Day Treatment ☐ H2012					
Day Treatment- Direct Care Staff (Rate per 15 min. unit) ☐ H2027 **Day Treatment- Family Psychotherapy without Client** Required after 144 units (15 min. increments) ☐ 90846					
Conference Regarding Client Treatment ☐ 90887					
Client Assistance Program (CAP) ☐ H0046					
Community Treatment Aide (CTA)(15 min.) ☐ H0036					

ASA SERVICES: ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION

Please indicate below which codes you are requesting.

Date of last ASA Assessment: _____ ASAM LOC Recommendation on ASA Assessment:_____

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
ASA Services: ☐ 90834 Outpatient Individual ☐ 90853 Outpatient Group ☐ 90846 Outpatient Family without identified client present ☐ 90847 Outpatient Family with identified client present					

Have traditional behavioral health services been attempted? (e.g. idividual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Additional Information?

For applicable service requests, please include the following information and corresponding clinical documentation: LOCUS/CASII Score _____ Intensity of Needs Level _____

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

Clinician Printed Name _____ Clinician Signature _____ Date _____