

**SUBMIT TO**  
**Utilization Management Department**  
 12515-8 Research Blvd., Suite 400  
 Austin, Texas 78759  
 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 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		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): _____				
					Risk of OOH Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice _____				
Last Date of substance use: _____					Attending AA/NA	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 MODIFIER, IF APPLICABLE)**

All out of network services require prior authorization, 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	Anticipated Completion Date of Service
Individual Psychotherapy Required after 12 units of combined bucket services  <input type="checkbox"/> 90832- 30 min. <input type="checkbox"/> 90833- 30 min. <input type="checkbox"/> 90834- 45 min. <input type="checkbox"/> 90836- 45 min. <input type="checkbox"/> 90837- 60 min. <input type="checkbox"/> 90838- 60 min.					
Individual Psychotherapy- Crisis Required after 12 units of combined bucket services  <input type="checkbox"/> 90939- 1st hour <input type="checkbox"/> 90840- additional 30 min.					
Group Psychotherapy <input type="checkbox"/> 90853					
Family Psychotherapy Required after 12 units of combined bucket services  <input type="checkbox"/> 90846- without identified client present <input type="checkbox"/> 90847- with identified client present  Child- Parent Psychotherapy Required after 12 units of combined bucket services  <input type="checkbox"/> 90847  Parent-Child Interaction Therapy (PCIT) Required after 12 units of combined bucket services  <input type="checkbox"/> 90847					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Functional Family Therapy <input type="checkbox"/> 90832- 30 min <input type="checkbox"/> 90834- 45 min. <input type="checkbox"/> 90837- 60 min. <input type="checkbox"/> 90846- without identified client present <input type="checkbox"/> 90847- with identified client present					
Multisystemic Therapy <input type="checkbox"/> H2033					
Professional Resource Family Care (PRFC) <input type="checkbox"/> T1027					
In-Home Psychiatric Nursing <input type="checkbox"/> S9123					
Day Treatment- Direct Care Staff (Rate per 15 min. unit) <input type="checkbox"/> H2027 Day Treatment- Family Psychotherapy without Client Required after 144 units (15 min. increments) <input type="checkbox"/> 90846					
Conference Regarding Client Treatment <input type="checkbox"/> 90887					
Client Assistance Program (CAP) <input type="checkbox"/> H0040					
Community Treatment Aide (CTA)(15 min.) <input type="checkbox"/> 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	Anticipated Completion Date of Service
ASA Services: <input type="checkbox"/> 90834 Outpatient Individual <input type="checkbox"/> H0005 Outpatient Group <input type="checkbox"/> 90846 Outpatient Family without identified client present <input type="checkbox"/> 90847 Outpatient Family with identified client present					

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?

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