SUBMIT TO
Utilization Management Department
13620 FM 620, Bldg C, Suite 300
Austin, Texas 78717
PHONE 1.844.385.2192 | FAX 1.866.593.1955

NONPAR 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
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	

REASONS FOR REQUESTING/ PROVIDING SERVICES OUT OF NETWORK

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

All out of network services require prior authorization, please indicate 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
Initial Diagnostic Interview ☐ 90791 ☐ 90792- with med services					
Annual Supervision by LIMHP or Psychologist ☐ H0031					
Medication Management ☐ 99211 ☐ 99212 ☐ 99213 ☐ 99214 ☐ 99215					
Individual Psychotherapy Required after first 2 units per member ☐ 90832- 30 min. ☐ 90833- 30 min. ☐ 90834- 45 min. ☐ 90836- 45 min. ☐ 90837- 60 min. ☐ 90838- 60 min.					
Individual Psychotherapy- Crisis Required after 12 units of combined bucket services ☐ 90939- 1st hour ☐ 90840- additional 30 min.					

	Date Service Started	Frequency: How often seen	Intensity: # Units per visit	Requested Start Date for this Auth	Requested End Date for this Auth
Group Psychotherapy ☐ 90853					
Family Assessment ☐ H1011 Family Psychotherapy Required after 12 units of combined bucket services ☐ 90846- without identified client present ☐ 90847- with identified client present Child-Parent Psychotherapy Required after 12 units of combined bucket services ☐ 90847 Parent-Child Interaction Therapy (PCIT) Required after 12 units of combined bucket services ☐ 90847					
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					
Professional Resource Family Care (PRFC) ☐ T1027					
In-Home Psychiatric Nursing ☐ S9123					
Day Treatment- Direct Care Staff (Rate per 15 min. unit) ☐ H2027					
Conference Regarding Client Treatment ☐ 90887					
Client Assistance Program (CAP) ☐ H0046					
Community Treatment Aide (CTA)(15 min.) ☐ H0036					
Office Consultation ☐ 99241- Low Complexity ☐ 99243- Medium Complexity ☐ 99245- High Complexity					
Inpatient Consultation ☐ 99251- Low Complexity ☐ 99253- Medium Complexity ☐ 99255- High Complexity					
Evaluation Management Nursing Home ☐ 99307 ☐ 99308 ☐ 99309 ☐ 99310					
Nursing Facility Consult ☐ 99304- Low Complexity ☐ 99305- Medium Complexity ☐ 99306- High Complexity					
Therapeutic Injections (Administered) ☐ 96372					

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
☐ 90853 ☐ H0001 ☐ 90834 Outpatient Individual ☐ H0005 Outpatient Group ☐ 90846 Outpatient Family without identified client present ☐ 90847 Outpatient Family with identified client present ☐ Opioid Treatment Program (list all codes being requested): OTP Code:_____ OTP Code:_____ OTP Code:_____ OTP Code:_____ OTP Code:_____ OTP Code:_____					

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

Clinician Printed Name

Clinician Signature Date