SUBMIT TO
Utilization Management Department
5900 E. Ben White Blvd.
Austin, TX 78741
PHONE 1-844-744-5315 | FAX 1-855-772-7079

wellcare By allwell.

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 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/your child currently take mental health medicines as prescribed by your doctor?	☐ Yes (5)	☐ No (0)
4. In the last 30 days, has alcohol or drug use caused problems for you or your child?	☐ Yes (0)	☐ No (5)
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 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 (0)	☐ No (5)
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 (5)	☐ No (0)
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 (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐	Hyperactivity/Inattn.	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Irritability/Mood Instability	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Hopelessness	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐	Other (include severity):	☐	☐	☐	☐

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐	Drug(s) of Choice:_____				

Last Date of Substance Use:_____

_____Member Name

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	
If prescribed medication, is member compliant?			☐ Yes	☐ No	

CURRENT MEASURABLE TREATMENT GOALS

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

	DATE SERVICE: STARTED	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
☐ Individual Therapy					
☐ Family Therapy					
☐ Group Therapy					

INTENSIVE OUTPATIENT/DAY TREATMENT SERVICES:

☐ REV 905 (Mental Health IOP)				
☐ REV 906 (CD IOP)				

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

☐				
☐				
☐				

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

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