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

superior healthplan™

OUTPATIENT TREATMENT REQUEST FORM

Instructions: Please fill out and print, or print form and fill out legibly in black ink.

MEMBER INFORMATION

Product: ☐ STAR/ MRSA ☐ STAR+PLUS ☐ CHIP/ RSA ☐ STAR Kids ☐ STAR Health

Member Name: _____ Member DOB: _____

Medicaid Number: _____

PROVIDER INFORMATION (INDIVIDUAL AND/OR GROUP)

Provider Name: _____ Phone Number: _____

Agency: _____ Fax Number: _____

Address: _____ NPI #: _____

City: _____ State: _____ Zip: _____ Tax ID #: _____

DSM OR ICD DIAGNOSIS

Primary: _____ Additional: _____

Secondary: _____ Additional: _____

Tertiary: _____

PRESENTING SYMPTOMS

Please describe in detail, including behavioral indicators: _____

_____

Residential/ Living Situation: _____

Has the member been diagnosed with a substance use disorder? ☐ N/A ☐ No ☐ Yes

Please specify1)substance, 2) amount, 3) duration/frequency, 4) age of first use, 5) date of last use_____ _____

_____

_____

Functional Impairments/Relationships: ☐ N/A ☐ Arguments/ Verbal hostility ☐ Decreased Social Contacts ☐ Easily Frustrated

Other/ Specify: _____

Functional Impairments/ Work or School: ☐ N/A ☐ Decreased Productivity ☐ Absent, # of days_____ ☐ Verbal/ Written Warning

☐ Suspended, # of days_____ Other/Specify: _____

Additional Functional Impairments: ☐ N/A ☐ Deterioration in ADLs ☐ Difficulty caring for dependent children/ vulnerable adults

☐ Complaints registered with child/ adult services/ authorities ☐ Medical LOA due to psychiatric disorder

Other: _____

_____

CURRENT TREATMENT

Progress (Check one): ☐ Initial Request ☐ Minimal ☐ Moderate ☐ Regressed ☐ No Progress

How has the progress been indicated? ☐ Patient Report ☐ Standard Instrument ☐ Parent Report

If no progress to date: Has the diagnosis been re-evaluated? ☐ N/A ☐ Yes ☐ No

Has the treatment plan been modified? ☐ N/A ☐ Yes ☐ No

If prescribed psychotropic medication, has the member been compliant? ☐ N/A ☐ Yes ☐ No

If no, please explain: _____

If a concurrent request, how many sessions of the past five has the member attended? _____

Is the member expected to adhere with treatment? ☐ Yes ☐ No Does the member have access to transportation? ☐ Yes ☐ No

If the member is in foster care, RTC, or a shelter? ☐ N/A If Yes, how long has the member been in the current placement? _____

TYPE(S) OF EVIDENCE-BASED THERAPY

SMART Goals for Treatment (Specific, Measurable, Attainable, Realistic, Time-Limited)

Goal 1: _____

Goal 2: _____

Goal 3: _____

RISK ASSESSMENT (CHECK ALL THAT APPLY)

Suicidal: ☐ None ☐ Ideation ☐ Plan ☐ Intent ☐ Self-Harming Behavior, specify: _____

Homicidal: ☐ None ☐ Ideation ☐ Plan ☐ Intent ☐ Agressive Behavior, specify: _____

Is there a Safety Plan in place?: ☐ Yes ☐ No

CARE COORDINATION

The member's care is being coordinated with the following individuals (Check all that apply):

☐ PCP_____ ☐ Psychiatrist_____ ☐ Other Therapist _____

☐ Other_____ If no coordination, why? _____

BARRIERS TO DISCHARGE/ DISCHARGE CRITERIA

_____

_____

REQUESTED TREATMENT

Please describe the member's support system and any environmental factors impacting their functioning: _____

_____

Please indicate the number of units you want for each visit and how frequently you will see the member. Ex: 1 unit, 4 times a month.

Modality and CPT Code	# Units per Session	Frequency	Requested Start Date	Duration of Request	Total # for this Request
☐ Individual Therapy (CPT Codes)					
☐ Couple/ Family Therapy (CPT Codes)					
☐ Group Therapy (CPT Codes)					
☐ H0004 HF Alcohol/Drug Individual Counseling (15 min. units)					
☐ H0005 Alcohol/ Drug Group Counseling (1 hr units)					
☐ H0034 Med Training/Support (STAR Health only) (15 min units)					
☐ 97352 Cognitive Rehabilitation (STAR+PLUS only)					
☐ H2014 Skills Training and Developement (CHIP/RSA) (15 min units)					
☐ H2017 Psychosocial Rehab Services (CHIP/RSA/STAR HEALTH) (18 plus) (15 min units)					
☐ Other					

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

_____ _____

My signature confirms that I am providing the requested service Date