

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



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healthplan™

Medicare  
Advantage

## 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	<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):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### FUNCTIONAL IMPAIRMENT (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: _____									

**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
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**BEHAVIORAL HEALTH OUTPATIENT SERVICES: (BILLED AS CPT CODES)**

<input type="checkbox"/> Individual Therapy				
<input type="checkbox"/> Family Therapy				
<input type="checkbox"/> Group Therapy				

**INTENSIVE OUTPATIENT/DAY TREATMENT SERVICES:**

<input type="checkbox"/> REV 905 (Mental Health IOP)				
<input type="checkbox"/> REV 906 (CD IOP)				

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

<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

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.

**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

\_\_\_\_\_  
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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