

**SUBMIT TO:**

**Utilization Management Department**

5900 E. Ben White Blvd.

Austin, Texas 78741

PHONE 1-844-259-3934

FAX 1-844-307-4442



FROM

**superior  
healthplan**

## 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?  | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |
| 2. In the last 30 days, have you had problems with fears and anxiety?  | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |
| 3. Do you currently take mental health medicines as prescribed by your doctor?   | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (5) |
| 4. In the last 30 days, has alcohol or drug use caused problems for you?   | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |
| 5. In the last 30 days, have you gotten in trouble with the law?   | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |
| 6. In the last 30 days, have you actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)? | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (5) |
| 7. In the last 30 days, have you had trouble getting along with other people including family and people outside the home?                 | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |
| 8. Do you feel optimistic about the future?  | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (5) |

**Children Only:**

- |   |                                  |                                 |
|---|----------------------------------|---------------------------------|
| 9. In the last 30 days, has your child had trouble following rules at home or school? | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |
| 10. In the last 30 days, has your child been placed in state custody (DCBS or DJJ)?   | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> No (0) |

**Adults Only:**

- |   |                                  |                                 |
|---|----------------------------------|---------------------------------|
| 11. Are you currently employed or attending school?                             | <input type="checkbox"/> Yes (0) | <input type="checkbox"/> No (5) |
| 12. In the last 30 days, have you been at risk of losing your living situation? | <input type="checkbox"/> Yes (5) | <input type="checkbox"/> 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**

\_\_\_\_\_

**Treatment Plan Changes**

\_\_\_\_\_

\_\_\_\_\_

Member Name \_\_\_\_\_

**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

**CURRENT MEASUREABLE TREATMENT GOALS**

Optional: Please provide a narrative or any additional documentation you feel will support this request.

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

SERVICE	FREQUENCY	INTENSITY	REQUESTED START	ANTICIPATED COMPLETION
Behavioral Health Outpatient Services	How Often Seen	# Units Per Visit	Date for this Auth	Date of Service
<input type="checkbox"/> Individual Psychotherapy—Mental Health				
<input type="checkbox"/> Individual Psychotherapy — Substance Use Disorder				

\_\_\_\_\_  
Clinician Printed Name

\_\_\_\_\_  
Clinician Signature

\_\_\_\_\_  
Date

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