

SUBMIT TO

Utilization Management Department

12515-8 Research Blvd., Suite 400

Austin, Texas 78759

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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 (DCFS or Juvenile 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.)

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING.	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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ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING

Assessment of Aphasia <input type="checkbox"/> 96105					
Alcohol and/or Drug Services <input type="checkbox"/> H0011 acute detoxification <input type="checkbox"/> H0012 sub-acute detoxification <input type="checkbox"/> H0014 ambulatory detoxification					
Respite Care(Does not require Authorization for up to 7 days. After 7 days Authorization is required) <input type="checkbox"/> H0045					
Community psychiatric supportive treatment <input type="checkbox"/> H0036 HO\HN\HM individual office <input type="checkbox"/> H0036 HO\HN\HM home or community <input type="checkbox"/> H0036 HO\HN mental health programs-(Homebuilders) <input type="checkbox"/> H0036 HE Face to face per 15minutes (FFT)					
Assertive community treatment program <input type="checkbox"/> H0039					
Psychiatric health facility service, per diem <input type="checkbox"/> H2013					
Psychosocial Rehabilitative Services <input type="checkbox"/> H2017 Individual Office <input type="checkbox"/> H2017 HA/HQ child/adolescent program, office group <input type="checkbox"/> H2017 HA/HQ child/adolescent program, group place of service 11 or 53 for home and community <input type="checkbox"/> H2017 HB/HQ adult program, non-geriatric, office group <input type="checkbox"/> H2017 HB/HQ adult program, non-geriatric group place of service 11 or 53 for home and community					
Foster Care, Therapeutic, Child; Per Diem <input type="checkbox"/> S5145					

