

SUBMIT TO

Utilization Management Department

12515-8 Research Blvd., Suite 400

Austin, Texas 78759

PHONE 1.866.595.8133 | FAX 1.844.466.1277



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, have you/your child used 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 |
|---|----------------------|---------------------------|------------------------------|------------------------------------|--|
|---|----------------------|---------------------------|------------------------------|------------------------------------|--|

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 | | | | | |

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?

Clinician printed name _____ Date _____

Date _____

Clinician Signature _____ Date _____

Date _____

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Have any questions? WWW.CENPATICO.COM
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Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).