

Outpatient Treatment Request



Outpatient Treatment Request

Fax completed form to: 866-949-4846

Fill out completely to avoid delays

Date: ___/___/___

Request Type (Check one): Standard Expedited (additional information required below)

Provider Attestation (Expedited Requests Only)

Clinical justification for expedited review: _____

By signing below, I certify that applying the standard review timeframe for this service request may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Physician/clinician name: _____ Signature: _____

Identifying Data

First: _____ Middle: _____ Last: _____

Health Plan ID: _____ Date of Birth: ___/___/___ Gender: Male Female

Address: _____ State: _____ Zip: _____

Provider Information

Provider name: _____ NPI#: _____

Phone: (_____) _____ Fax: (_____) _____

Other Current BH Provider(s) _____

Check one:

- Member agreed to release of information to their PCP and/or other treating providers dated _____.
- Member has been informed for release of information and has declined.

Diagnoses

Axis I		Axis V	
Axis II		Axis IV	
Axis III		Highest GAF in past year:	

Psychotropic Medications

Medication	Previous or current?	Changed since last report?	Dosage	Frequency	Adherent?

Clinical Information

Check all that apply

Symptoms						Symptoms					
	Mild	Moderate	Severe	Acute	Persistent		Mild	Moderate	Severe	Acute	Persistent
Anxiety Disorders						Psychotic Disorders					
• Obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Delusions/paranoia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Generalized Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Self-care deficits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Hallucinations, Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Responding to internal stimuli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Somatic complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Disorganized thought process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• PTSD symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Loose associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression						Substance Use Disorder					
• Impaired concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Loss of control of dosage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Impaired memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Amnesic episodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Psychomotor retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Legal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sexual issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Appetite disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Opiate abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Prescription medication abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Polysubstance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Hopelessness/Helplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personality Disorder					
• OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Oddness/eccentricities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mania/Hypomania						• Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Disregard for law	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Grandiosity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Recurring self-injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Pressured Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Sense of entitlement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Racing thoughts/flight of ideas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Passive aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Poor judgment/impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Sexual preoccupation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• OTHER:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Co-occurring Medical Conditions

Symptoms	Mild	Moderate	Severe	Acute	Chronic		Symptoms	Mild	Moderate	Severe	Acute	Chronic
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Factors

Check all that apply

Risk Factors	None	Ideation with plan	Ideation without plan	Intent with means	Intent without means	Current?	History?
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse	None	<i>Patient is...</i>		Does abuse or neglect involve a child or elder?	Abuse has been legally reported	Current?	History?
		Victim	Perpetrator				
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

(Last 3 years if known)

	Barriers / Risk Factors	Current or History?	Current Supports/Protective Factors
Family/Interpersonal relationships			
Job/School			
Housing			
Family History of Mental Illness / Substance Use Disorder			

Treatment History

All levels of care

Level of Care	# of distinct episodes/sessions	Date of last treatment		Level of Care	# of distinct episodes/sessions	Date of last treatment
Inpatient psychiatric				Intensive Outpatient (IOP)		
Inpatient Substance Use Disorder				Outpatient psych (individual or group)		
Partial Hospitalization (PHP)				Outpatient substance abuse (individual or group)		

Treatment Goals and Outcomes

Complete fields below and/or attach current treatment plan

Treatment Goals
1.
2.
3.
Objective outcome criteria by which goal will be measured:
1.
2.
3.
Expected Outcome and Prognosis (check all that apply)
<input type="checkbox"/> Return to normal functioning
<input type="checkbox"/> Expected improvement, anticipated less than baseline functioning
<input type="checkbox"/> Relieve acute symptoms, return to baseline functioning
<input type="checkbox"/> Maintain current status, prevent deterioration
Discharge/Termination Plan (include estimated discharge date)

Requested Authorizations					
	Service	Code	# Units requested	Service Start Date	Service End Date
1					
2					
3					

Requested by:	Phone:	Fax:

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