Outpatient Treatment Request

Fax completed form to: 866-949-4846

Fill out completely to avoid delays

Request Submission 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: _____

Customer ID: _____**Date of Birth:** ____/____/_____ Gender: ☐Male ☐ Female

Address: _____

City: _____ **State:** _____ **Zip:** _____

Requested Authorizations

	Service	Code	# Units requested	Service Start Date	Service End Date
1					
2					
3					
4					

Provider Information

Name *(program, facility or provider)*: _____ **NPI#:** _____

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

To whom should the authorization determination be sent? Name: _____

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

Other 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.

Diagnosis ICD 10 Codes

Psychotropic Medications

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

Clinical Narrative

Provide information to support this request symptoms, risk factors, social history, substance abuse history , etc.

Co-occurring Medical Conditions

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)	
☐	Return to normal functioning
☐	Expected improvement, anticipated less than baseline functioning
☐	Relieve acute symptoms, return to baseline functioning
☐	Maintain current status, prevent deterioration

Discharge/Termination Plan (include estimated discharge date)

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