home state health

SUBMIT TO
Utilization Management Department
Phone: 1.866.864.1459 FAX 1.866.694.3649

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 _____

DSM-IV TR 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/your child had problems with sleeping or feeling sad?	☐ Yes (5)	☐ No (0)
2. In the last 30 days, have you/your child 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 (0)	☐ No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you or your child?	☐ Yes (5)	☐ No (0)
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 outside the home?	☐ Yes (5)	☐ No (0)
8. Do you/your child feel optimistic about the future?	☐ Yes (0)	☐ No (5)
Children Only:		
9. In the last 30 days, has your child had trouble following rules at home or school?	☐ Yes (5)	☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)?	☐ Yes (5)	☐ No (0)
Adults Only:		
11. Are you currently employed or attending school?	☐ Yes (0)	☐ No (5)
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.)

	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐
Decreased Energy	☐	☐	☐
Delusions	☐	☐	☐
Depressed Mood	☐	☐	☐
Hallucinations	☐	☐	☐
Angry Outbursts	☐	☐	☐

	Mild	Moderate	Severe
Hyperactivity/Inattn.	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐
Impulsivity	☐	☐	☐
Hopelessness	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐

Other (include severity):

FUNCTIONAL IMPAIRMENT SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	Mild	Moderate	Severe
ADLs	☐	☐	☐
Relationships	☐	☐	☐
Substance Use Disorder	☐	☐	☐
Physical Health	☐	☐	☐
Work/School	☐	☐	☐

Last Date of substance use:_____

Drug(s) of Choice:_____

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.)

SERVICE	DATE SERVICE STARTED	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Individual Therapy					
Family Therapy					
Group Therapy					
Hypnotherapy (90880)					
Telemedicine (Q3014)					

NON-PARTICIPATING PROVIDER - PLEASE INDICATE ANY ADDITIIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR.

OTHER CODES REQUESTED:					
☐					
☐					
☐					

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?

PROVIDER NAME PROVIDER SIGNATURE DATE

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

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