



SUBMIT TO  
**Utilization Management Department**  
 12515-8 Research Blvd., Suite 400  
 Austin, Texas 78759  
 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		Mild	Moderate	Severe	Other (include severity):
Anxiety/Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/Inattn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Angry Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Have any questions?  
 Call us at 1.866.864.1459

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

	Mild	Moderate	Severe		Mild	Moderate	Severe
ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Disorder	<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.)

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 ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR.

**OTHER CODES REQUESTED:**

<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

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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