Please print clearly. Incomplete or illegible forms will delay processing.

SUBMIT TO:
Cenpatico
504 Lavaca, Suite 850
Austin, TX 78701
FAX: 866 694-3649

DATE: _____/_____/_____

MEMBER INFORMATION

NAME: _____
DOB: _____/_____/_____
MEMBER ID #: _____
HEALTH PLAN: _____

PROVIDER INFORMATION

PROVIDER NAME: _____
PROVIDER TX ID #: _____
PROVIDER NPI/Sub provider #: _____
PROVIDER PHONE #: _____
PROVIDER FAX #: _____

DSM-IV TR DIAGNOSIS

AXIS I: __ __ __. __ __/__ __ __ . __ __/__ __ __ . __ __ **AXIS II:** __ __ __. __ __/__ __ __ . __ __/__ __ __ . __ __ **AXIS III:** _____

Axis IV: _____ **Axis V:** _____ **Has contact occurred with PCP?** □ Yes □ No

Date first seen: _____ **Date last seen:** _____

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 (5)	□ No (0)
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/you 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 (DCBS or DJJ)?	□ 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 (√)

	Mild	Mod.	Severe		Mild	Mod.	Severe	
Anxiety/Panic Attacks	□	□	□	Hyperactivity/Inattn.	□	□	□	Other (include severity): _____
Decreased Energy	□	□	□	Irritability/Mood Instability	□	□	□	_____
Delusions	□	□	□	Impulsivity	□	□	□	_____
Depressed Mood	□	□	□	Hopelessness	□	□	□	_____
Hallucinations	□	□	□	Other Psychotic Symptoms	□	□	□	
Angry Outbursts	□	□	□					

FUNCTIONAL IMPAIRMENT

ADLs	□	□	□	Physical Health	□	□	□
Relationships	□	□	□	Work/School	□	□	□
Substance Abuse	□	□	□	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 self-harming behavior
Safety Plan in place? (if plan or intent indicated): □ Yes □ No
Medical Psychiatric Evaluation completed? □ Yes □ No **If prescribed medication, is member compliant?** □ Yes □ No

CURRENT MEASUREABLE TREATMENT GOALS:

Requested Authorization (Please check off appropriate box to indicate modifier, if applicable)

SERVICE	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # UNITS PER VISIT	REQUESTED START DATE FOR AUTH	ANTICIPATED COMPLETION DATE OF SERVICE
Behavioral Health Outpatient Services (billed as CPT codes):				
□ Individual Therapy				
□ Family Therapy				
□ Group Therapy				
□ **Hypnotherapy (90880)**				
□ **Telemedicine (Q3014)**				

If you are a nonparticipating provider only, please indicate here any additional codes you are requesting authorization for.
Other code(s) requested:

Provider's Name (Printed) **Provider's Signature** **Date**