



Upon completion of this form **please fax to 1-833-966-0769.**

Facility Name		
Facility NPI #		
Contact Person Name		
Phone #		
Fax #		
Level of Care / CPT Code Requested		
Modifiers		
Request Date		
Member Name/DOB		
Attending Physician Name / #		
Other Insurance <i>(any changes)</i>		
Guardian name and phone# <i>(any changes)</i>		
RCST/phone # <i>(any changes)</i>		
Court Commit / Ordered <i>(any changes)</i>	Yes ☐ No ☐	If yes, please attach changes only

Updated DX

1.	
2.	
3.	
4.	
5.	
6.	

Current Symptoms/Behaviors/Functional Deficits/Needs that necessitate continued stay at current level of care.
Please tell us why member can't be treated at a lower level of care:

If applicable — bio/foster family contact (can include phone calls/passes/FT sessions):

List or narrative of reports below (This can consist of therapy/psych notes with current updates/progress)

Behavioral Health Report:

Mental Health/Trauma Report:

Education Report:

Significant incidents from the last reporting period:

Is member on any special precautions?

Current Medications:

Name and dose of medication	Start date	Adjustments to Med	Reason for Medication	Any significant updates

Is member compliant with taking meds:	Yes ☐ No ☐
If no, explain:	
Any comments regarding meds:	

OUTPATIENT APPOINTMENTS IN LAST REPORTING PERIOD

Provider	Service	Date
Comments/concerns:		

DATES OF SESSIONS THIS REPORTING PERIOD

Individual Therapy	Group Therapy	Family Therapy	Treatment Plan Meeting	Other

Treatment Plan Updates/Notes:
Discharge Plan/Follow Up:
Discharge disposition:

What movement has there been regarding discharge during this reporting period?

Barriers to discharge:

Tentative timeline for discharge: