SUBMIT TO
**Utilization Management Department**
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Phone: 1.877.725.7748 FAX: 1.844.733.8482

allwell. FROM | peach state health plan.

# 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 _____

## CURRENT ICD DIAGNOSIS

*Primary_____

Secondary _____

Tertiary _____

Additonal _____

Additonal _____

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 had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you had problems with fears and anxiety? ☐ Yes (5) ☐ No (0)
3. Do you 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? ☐ Yes (5) ☐ No (0)
5. In the last 30 days, have you gotten in trouble with the law? ☐ Yes (5) ☐ No (0)
6. In the last 30 days, have you 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 had trouble getting along with other people including family and people out the home?
   ☐ Yes (5) ☐ No (0)
8. Do you feel optimistic about the future? ☐ Yes (0) ☐ No (5)
9. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
10. 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

| | N/A | Mild | Moderate | Severe | | N/A | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| Anxiety/Panic Attacks | ☐ | ☐ | ☐ | ☐ | Hyperactivity/Inattn. | ☐ | ☐ | ☐ | ☐ |
| Decreased Energy | ☐ | ☐ | ☐ | ☐ | Irritability/Mood Instability | ☐ | ☐ | ☐ | ☐ |
| Delusions | ☐ | ☐ | ☐ | ☐ | Impulsivity | ☐ | ☐ | ☐ | ☐ |
| Depressed Mood | ☐ | ☐ | ☐ | ☐ | Hopelessness | ☐ | ☐ | ☐ | ☐ |
| Hallucinations | ☐ | ☐ | ☐ | ☐ | Other Psychotic Symptoms | ☐ | ☐ | ☐ | ☐ |
| Angry Outbursts | ☐ | ☐ | ☐ | ☐ | Other (include severity): _____ | | | | |

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

| | N/A | Mild | Moderate | Severe | | N/A | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|
| ADLs | ☐ | ☐ | ☐ | ☐ | Physical Health | ☐ | ☐ | ☐ | ☐ |
| Relationships | ☐ | ☐ | ☐ | ☐ | Work/School | ☐ | ☐ | ☐ | ☐ |
| Substance Abuse | ☐ | ☐ | ☐ | ☐ | Drug(s) of Choice: _____ | | | | |

Last Date of substance use:_____

Member Name _____

## 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 | |
| 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 | Date Service Started | FREQUENCY: How Often Seen | INTENSITY: # Units Per Visit | Requested Start Date for this Auth | Anticipated Completion Date of Service |
|---|---|---|---|---|---|

**IF YOU ARE A NON PARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR:**

**OTHER CODE(S) 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?

**STANDARD REVIEW:**
Standard 14-day time frame will be applied.

Clinician Signature _____ Date _____

**EXPEDITED REVIEW:** By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature _____ Date _____

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

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