SUBMIT TO
Utilization Management Department
1100 Circle 75 Parkway, Suite 1100
Atlanta, GA 30339
Phone: 1.800.704.1483 FAX: 1.844.870.5064

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)

Children

9. In the last 30 days, has your child had trouble following the 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

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

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

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

Other (include severity):____

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

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐

Last Date of substance use:_____________________________

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐

Drug(s) of Choice:____

______________________________________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:	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
Behavioral Health Outpatient Services: (billed as CPT codes)				
❑ Individual Therapy				
❑ Family Therapy				
❑ Group Therapy				
Group/Family Psychotherapy (billed as CPT codes) ❑ H0004				
Ambulatory Detox ❑ 90853 (w/ Art Therapy) (one per day)				
Intensive Family Intervention ❑ H0036 (15 min units)				
Adult Peer Supports ❑ H0038 (15 min units) ❑ H0038HF Group (15 min units) ❑ H0025 Peer Support Whole Health & Wellness (15 min units)				
Assertive Community Therapy ❑ H0039 (15 min units)				
Crisis Management ❑ H2011 (15 min units)				
Family/Group Skills Training ❑ H2014 (15 min units)				
Community Support-- **C&A only** ❑ H2015 (15 min units)				
Addictive Disease Support --**Adult Only** ❑ H2015 (15 min units)				
Case Managment--**Adult Only** ❑ T1016 (15 min units) ❑ T 1016 HK for INtensive CM (15 min units)				

If you are a nonparticipating provider only. Please indicated here an additional codes you are requesting authorization for. Othercodes requested:

❑				
❑				

Additional Information?

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?

____

Clinician Signature Date

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