

SUBMIT TO
Utilization Management Department
 Phone: 1-855-565-9519 Fax: 1-844-824-7705



OUTPATIENT TREATMENT REQUEST FORM

Date _____ Please print clearly – incomplete or illegible forms will delay processing.

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 _____
 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 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/Inattn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice: _____				
Last Date of substance use: _____									

