FROM |

home state health

SUBMIT TO:
Utilization Management Department
PHONE 1.844.265.1278 FAX 1.844.481.6729

OUTPATIENT TREATMENT REQUEST FORM

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

Date ______________________________

MEMBER INFORMATION

First Name ______________________________

Last Name ______________________________

DOB ______________________________

Member ID # ______________________________

PROVIDER INFORMATION

Provider Name (print) ______________________________

Provider/Agency Tax ID # ______________________________

Provider/Agency NPI Sub Provider # ______________________________

Phone ______________ Fax ______________

CURRENT ICD DIAGNOSIS

Primary (Required) ______________________________

Secondary ______________________________

Tertiary ______________________________

Additional ______________________________

Additional ______________________________

Has contact occurred with PCP? ❑ Yes ❑ No

Date first seen by provider/agency ______________________________

Date last seen by provider/agency ______________________________

SPMI/SED ❑ Yes ❑ No

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT.)

Question	Yes	No
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 outside the home?	❑ Yes (5)	❑ No (0)
8. Do you 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 Termination

____

____

Treatment Plan Changes

____

____

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Member Name ____

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

	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): ________________				
Risk of OOH Placement	❏	❏	❏	❏

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

	N/A	Mild	Moderate	Severe
ADLs	❏	❏	❏	❏
Relationships	❏	❏	❏	❏
Substance Use	❏	❏	❏	❏

Last Date of substance use: ______________________________

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

Drug(s) of Choice ____

Attending AA/NA ❏ Yes ❏ No

RISK ASSESSMENT

Suicidal	❏ None	❏ Ideation	❏ Planned	❏ Imminent Intent	❏ History of self-harming behavior
Homicidal	❏ None	❏ Ideation	❏ Planned	❏ Imminent Intent	❏ History of harm to others

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

Optional: Please provide a narrative or any additional documentation you feel will support this request.

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

SERVICE Behavioral Health Outpatient Services	FREQUENCY How Often Seen	INTENSITY # Units Per Visit	REQUESTED START Date for this Auth	ANTICIPATED COMPLETION Date of Service
❏ Individual Psychotherapy — Mental Health				
❏ Individual Psychotherapy — Substance Use Disorder				

Clinician Printed Name ____________ Date ____________

Clinician Signature ____________ Date ____________

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