Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date _____

Carrier or Appropriate Recipient:

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH ☐☐ / ☐☐ / ☐☐

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE

Date Patient First Seen For This Episode Of Treatment __/__/____

Level of care being requested: Please specify benefit type:

☐ Mental Health ☐ Substance Use Disorder ☐ Outpatient ☐ Intensive Outpatient Program ☐ Partial Hospitalization Program ☐ Acute IP ☐ IP Rehab ☐ Acute IP Detox ☐ Residential ☐ ECT ☐ rTMS ☐ Applied Behavior Analysis (ABA) ☐ Psychological Testing ☐ BioFeedback ☐ Telehealth ☐ Other _____

Primary Dx Code: _____ **Secondary Dx Code(s):** _____

Current Treatment Modalities: (check all that apply)

Psychotherapy: ☐ Behavioral ☐ CBT ☐ DBT ☐ Exposure ☐ Supportive Therapy ☐ Problem Focused ☐ Interpersonal ☐ Psychodynamic ☐ EMDR ☐ Group ☐ Couples ☐ Family ☐ Other_____

☐ **Medical Evaluation and Management**

Type of Medications(if not applicable, no response is required):

☐ Antipsychotic ☐ Anxiolytic ☐ Antidepressant ☐ Stimulant ☐ Injectables ☐ Hypnotic ☐ Non-psychotropic ☐ Mood Stabilizer ☐Other _____

Current Symptoms and Functional Impairments: Rate the patient's current status on these symptoms/functional impairments, if applicable.

	Current Ideation	Current Plan	Prior Attempt	None
Suicidal	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐

Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	☐	☐	☐	☐
Substance Use Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Agitated/aggressive Behavior	☐	☐	☐	☐
Mood Instability	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Cognitive Impairment	☐	☐	☐	☐
Eating Disorder Symptoms	☐	☐	☐	☐
Social/ Familial/School/WorkProblems	☐	☐	☐	☐
ADL Problems	☐	☐	☐	☐

If requesting additional outpatient care for a patient, why does the patient require further outpatient care: ☐ Maintenance treatment for a chronic condition ☐ Consolidate treatment gains ☐ Continued impairment in functioning ☐ Significant regression ☐ New symptoms and/or impairments ☐ Supportive treatment due to other treatment plan changes ☐ complex psychiatric and medical co-morbidity ☐ Complex Psychiatric and Substance abuse Co-morbidity

☐ other_____

Signature of Practitioner: _____ Date: _____/_____/_____

My signature attests that I have a current valid license in the state to provide the requested services.

***Complete the following if the request is for ECT or rTMS*:** Provide clinical rationale including medical suitability and history of failed treatments:

_____

_____

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following for Applied Behavior Analysis (ABA) Requests(if the carrier classifies ABA as a mental health benefit):

Supervising BCBA Name_____ Has Autism Spectrum Disorder been validated by MD/DO or Psychologist? □Yes □No

For initial requests, what are specific ABA treatment goals for the patient?

1. _____
2. _____
3. _____

Date of Evaluation by MD/DO: _____

For continuing requests, assessment of functioning (observed via FBA, ABLLS, VB-MAPP, etc.) related to ASD including progress over the last year:

_____

_____

_____

For continuing requests what are the treatment goals and targeted behaviors, indicating new or continued, with documentation of progress and child's response to treatment:

1._____
2._____
3._____

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Psychological Testing:

Symptoms/Impairment related to need for testing:

□ Acute change in functioning from the individual's previous level
□ Peculiar behaviors and/or thought process
□ Symptoms of psychosis
□ Attention problems
□ Development delay
□ Learning difficulties
□ Emotional problems
□ Relationship issues
□ Other:_____
□ Personality problems
□ School problems
□ Family issues
□Cognitive impairment
□ Mood Related Issues
□ Neurological difficulties
□ Physical/medical signs

Purpose of Psychological Testing:

□ Differential diagnostic clarification
□ Help formulate/reformulate effective treatment plan.
□ Therapeutic response is significantly different from that expected based on the treatment plan.
□ Evaluation of functional ability to participate in health care treatment.
□ Other: (describe) _____

Substance use in last 30 days: □ Yes □ No Diagnostic Assessment Completed: □ Yes Date _____/_____/_____ □ No
Patient substance free for last ten days □ Yes □ No
Has the patient had known prior testing of this type within the past 12 months? □ Yes □ No
If so, why necessary now? □ Unexpected change in symptoms □ Evaluate response to treatment □ Assess functioning □ Other
Names and Number of Hours of each requested test_____

If appropriate, complete this section: Reason(s) why assessment will require more time relative to test standardization samples?

□ Depressed mood	□ Vegetative Symptom	□ Processing speed	□ Performance Anxiety	□ Expressive/ Receptive Communication Difficulties
□ Low frustration tolerance	□ Suspected or Confirmed grapho-motor deficits	□ Physical Symptoms or Conditions such as:_____ _____	□ Other:_____ _____ _____	

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Biofeedback:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Telehealth:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete for Higher Level of Care Requests (e.g. inpatient, residential, intensive outpatient and partial hospitalization):

Primary reason for request or admission: (check one) □ Self/Other Lethality Issues □ Violent, unpredictable/uncontrolled behavior
□ Safety issues □ Eating Disorder □ Detox/withdrawal symptoms □ Substance Use □Psychosis □ Mania □ Depression
□ Other _____

Why does this patient require this higher level of care at this time? (Please provide frequency, intensity , duration of impairing behaviors and symptoms):_____
_____

Medication adjustments (medication name and dose) during level of care: _____
_____
_____

Barriers to Compliance or Adherence: _____

Prior Treatment in past 6 months:
□ Mental Health □ Substance Use Disorder □ Inpatient □ Residential □ Partial □ Intensive Outpatient □ Outpatient

Relevant Medical issues (if any): _____
_____

Support System/Home Environment: _____
_____
_____

Treatment Plan (include objectives, goals and interventions):_____
_____
_____

If Concurrent Review—What progress has been made since the last review_____
_____
_____

Why does member continue to need level of care_____
_____
_____

Discharge Plan (including anticipated discharge date)_____
_____
_____

Complete the following if substance use is present for higher level of care requests:
Type of substance use disorder _____
Onset: □ Recent □ Past 12 Months □ More than 12 months ago
Frequency: □ Daily □ Few Times Per Week □ Few Times Per Month □ Binge Pattern
Last Used: □ Past Week □ Past Month □ Past 3 Months □ Past Year □ More than one year ago
Consequences of relapse: □ Medical □ Social □ Housing □ Work/School □ Legal □ Other _____
Urine Drug Screen: □ Yes □ No Vital Signs: _____
Current Withdrawal Score: (CIWA_____ COWS_____) or Symptoms (□ check if not applicable) _____
_____
History of: □ Seizures □ DT's □ Blackouts □Other □ Not Applicable

Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:
Height: _____ Weight:_____ % of NBW_____
Highest weight_____ Lowest weight_____ Weight change over time (e.g. lbs lost in 1 month) _____
If purging, type and frequency _____ Potassium _____ Sodium _____ Vital signs _____
Abnormal EKG_____ Medical Evaluation □ Yes □ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues: _____
_____
Please include any current medical/physiological pathologic manifestations: _____
_____
_____