COVER SHEET NOT REQUIRED

Fax: 1-888-656-2168

TREATMENT REQUEST FORM
(TRF)

MEMBER INFORMATION

MEMBER'S FIRST NAME | MEMBER'S LAST NAME

DATE OF BIRTH | MEMBERSHIP MEDICAID ID NUMBER

PRIOR AUTHORIZATION NUMBER
(IF APPLICABLE)

PROVIDER INFORMATION

PROVIDER MIS # | PHONE

PROVIDER NAME & ADDRESS

REQUESTED SERVICES

***= Required Information**

***Requested Start Date for this TRF (MM/DD/YYYY)**

***Primary Diagnosis**

Secondary Diagnosis

***CPT CODE: Select Code(s) Requested:**

☐	**90832** Psychotherapy 30 min **90833** 30 min Psychotherapy (add-on code)± **90834** Psychotherapy 45 min **90836** 45 min Psychotherapy (add-on code)± **90837** Psychotherapy 60 min	☐	**90838** 60 min Psychotherapy (add-on code)± **90846** Family Therapy w/o member **90847** Family Therapy member present **90853** Group Therapy, Not Multiple Family

±Billing for these codes must be accompanied by a corresponding E&M code, e.g., 99212

Q1. Are services primarily for Mental Health ☐ or Substance Use Disorder ☐ ?

Q2. Have you seen this member in the last 90 days? Yes ☐ No ☐

Q3. Have you previously submitted a TRF (Concurrent Authorization) request for this member? Yes ☐ No ☐

Q4. Is this an EPSDT request for extension beyond the 26 annual sessions? Yes ☐ No ☐

Q5. Is this member on a medication prescribed by you or another practitioner to treat this condition? Yes ☐ No ☐

Complete Section A only if you marked Mental Health (MH) on Q1 and No on Q2.
Complete Section B only if you marked Substance Use Disorder (SUD) on Q1 and No on Q2.
Complete Section C only if you answered Yes to Q2 and Yes to Q3
Complete Sections A and C, if you marked MH on Q1 and Yes on Q2 and No on Q3.
Complete Sections B and C, if you marked SUD on Q1 and Yes on Q2 and No on Q3.

A. New Episode of Care Request for Primarily Mental Health or Psychiatric Diagnosis (Answer each question)

Date initial Plan of Care signed:

Member expected to adhere with treatment Yes ☐ No ☐

Transportation available Yes ☐ No ☐

Safety Risk: None to minimal ☐ Possibly ☐ Imminent or high ☐

Impairment in functioning with change in baseline within last month Yes ☐ No ☐

Treatment is necessary to sustain behavioral or emotional gains or to restore cognitive functional levels that have been impaired Yes ☐ No ☐

Member is at risk for developing or requires treatment for maladaptive coping strategies Yes ☐ No ☐

Member presents a reduction in individual adaptive and coping mechanisms or demonstrates extreme increase in personal distress Yes ☐ No ☐

Symptoms and behavior indicated need for outpatient treatment Yes ☐ No ☐

Treatment intervention(s) are not experimental Yes ☐ No ☐

B. New Episode of Care Request for Primarily Substance Use Disorder Diagnosis (Answer each question)

Date initial Plan of Care signed:

Member expected to adhere with treatment Yes ☐ No ☐

Support system available and competent Yes ☐ No ☐

Transportation available Yes ☐ No ☐

Member poses risk or harm to self or others? Yes ☐ No ☐

Meets all of ASAM Level I outpatient dimensional requirements? Yes ☐ No ☐

C. Additional Sessions or Continued Stay Request for Psychiatric or Substance Use Disorder diagnosis (Answer each question)

Date latest Plan of Care signed:

Psychosocial assessment completed Yes ☐ No ☐

Confirm Substance Use Disorder and/or Medication Evaluations completed if needed Yes ☐ No ☐ N/A ☐

Symptoms and behaviors indicate need for continued outpatient treatment Yes ☐ No ☐

Has member received treatment besides outpatient therapy or medication management? Yes ☐ No ☐

Has member no showed at least twice (three times for mental health treatment in members age 13-17) out of the last five authorized visits or shown other similar indications of not adhering to treatment? Yes ☐ No ☐

Has member shown No progress ☐ Minimal progress ☐ Moderate progress ☐ Significant progress ☐

***Print name of treating provider** ***Date (MM/DD/YYYY)**

Only treating providers or their office personnel may submit this form. By submission of this TRF, I attest that the treating provider has a current valid license in Virginia to provide the requested services, and has collected all appropriate co pays and coinsurance.

Submit your request online to www.MagellanofVirginia.com for real-time response. Also on this site you can check member eligibility, authorization and claim status, view outcomes reports, access clinical guidelines, earn CEUs and much more.