

DATE \_\_\_\_\_

**MEMBER INFORMATION**

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

MEMBER ID # \_\_\_\_\_

**PROVIDER INFORMATION**

PROVIDER NAME \_\_\_\_\_

PROVIDER/AGENCY TAX ID # \_\_\_\_\_

PROVIDER/AGENCY NPI SUB PROVIDER # \_\_\_\_\_

PHONE \_\_\_\_\_ FAX \_\_\_\_\_

**DSM-IV TR DIAGNOSIS**

AXIS I \_\_\_\_\_

AXIS II \_\_\_\_\_

AXIS III \_\_\_\_\_

AXIS IV \_\_\_\_\_

AXIS V \_\_\_\_\_

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/your child had problems with sleeping or feeling sad?  Yes (5)  No (0)
2. In the last 30 days, have you/your child had problems with fears and anxiety?  Yes (5)  No (0)
3. Do you/your child 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 or your child?  Yes (5)  No (0)
5. In the last 30 days, have you/your child gotten in trouble with the law?  Yes (5)  No (0)
6. In the last 30 days, have you/your child 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/your child had trouble getting along with other people including family and people outside the home?  
 Yes (5)  No (0)
8. Do you/your child 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 (DCF criminal justice)?  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 DISCHARGE**

**SYMPTOMS** (If present, check degree to which it impacts daily functioning.)

	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 Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice: _____				
Last Date of Substance use: _____									

**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
- 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	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # UNITS PER VISIT	REQUESTED START DATE FOR THIS AUTH	ANTICIPATED COMPLETION DATE OF SERVICE
Behavioral Health Outpatient Services: Individual Therapy (billed as CPT codes)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15		
Behavioral Health Outpatient Services: Family Therapy (billed as CPT codes)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15		
Behavioral Health Outpatient Services: Group Therapy (billed as CPT codes)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15		
ESP (Emergency Services Program/ Assessment) <input type="checkbox"/> S9484 (1 hour units)					
Ambulatory Detoxification <input type="checkbox"/> H0014 (per diem)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15		
Structured Outpatient Addiction Program <input type="checkbox"/> H0015 (per diem)			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15		
Mobile Crisis/Crisis Intervention <input type="checkbox"/> H2011 (15 min units)					
Community Support Services <input type="checkbox"/> H2015 (15 min units)					
Family Stabilization Services <input type="checkbox"/> H2019 (15 min units)					
Acupuncture Detox <input type="checkbox"/> 99407 <input type="checkbox"/> 97811					

**If you are a nonparticipating provider only, please indicate here any additional codes you are requesting authorization for. Other code(s) requested:**

<input type="checkbox"/>					
<input type="checkbox"/>					
<input type="checkbox"/>					

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?

Additional information?

PROVIDER NAME \_\_\_\_\_ PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).**

SUBMIT TO: **Utilization Management Department** 12515-8 Research Blvd, Suite 400, Austin, Texas 78759 PHONE 866.896.5053 FAX 866.694.3649