



Submit to:

OUTPATIENT TREATMENT REQUEST (OTR)

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

Member Information

Patient Name: _____

Health Plan: _____

DOB: _____

SS#: _____

Patient ID#: _____

Last Auth. #: _____

Provider Information
(Please indicate by checking below, whether requested services should be authorized to the provider or agency.)

____ Provider Name (print): _____

Professional Credential: ___ MD ___ PhD ___ Other _____

____ Group/Agency Name: _____

Physical Address: _____
(street address, city, state, zip)

Phone: _____ Fax: _____

Medicaid/TPI/NPI #: _____ Tax ID #: _____

Previous BH/SA Treatment

None or OP MH SA and/or IP MH SA

List names & dates, include hospitalizations: _____

Substance Abuse: None By History and/or Current/Active

Substance(s) used, amount, frequency & last used: _____

DSM IV Axis:

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____ CURRENT _____ PAST YEAR _____

Treatment Goals

List primary complaint/problem to be addressed: _____

Discharge Criteria

Objectively describe how you will know that the patient is ready to discontinue treatment: _____

Please answer YES or NO to the following questions:

Are the Member's family/supports involved in treatment? _____

Coordination of care with other behavioral health providers? _____

Coordination of care with medical providers? _____

Has Member been evaluated by a Psychiatrist? _____

Primary Medical Physician (PMP) Communication

Has information been shared with the PMP regarding:

- The initial evaluation & treatment plan? Yes No
- This updated evaluation & treatment plan Yes No

PMP Name/Date last notified: _____

If No, explain: _____

Current Risk/Lethality

Suicidal	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*
Homicidal	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*
Assault/ Violent Behavior	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*

Progress/Compliance

*Overall Progress toward goal:

<input type="checkbox"/> 1 NONE*	<input type="checkbox"/> 2 MIN*	<input type="checkbox"/> 3 MOD	<input type="checkbox"/> 4 MAX	<input type="checkbox"/> 5 MET
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*Compliance with treatment:

<input type="checkbox"/> 1 NONE*	<input type="checkbox"/> 2 MIN*	<input type="checkbox"/> 3 MOD	<input type="checkbox"/> 4 MAX	<input type="checkbox"/> 5 MET
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Requested Authorization

Services requested: Individual Group Family Med Management

ECT (Call Medical Management to discuss request)

Total sessions requested this OTR: _____ CPT codes: _____

Est. # of sessions to complete treatment episode: _____

Requested start date for authorization: _____

Medical Psychiatric Eval done? (even if PMP providing meds) Yes No

Medication given by Psychiatrist PMP N/A

Current Risk/Lethality *3-5, Progress/Compliance *1-2 checked, give intervention: _____

Provider Signature/Date: _____

For Office Use Only:

Individual/Family therapy: # of approved units: _____ Expires: _____

Group therapy: # of approved units: _____ Expires: _____

Medication Management: # of approved units: _____ Expires: _____

ECT: # of approved units: _____ Expires: _____

Reviewed by: _____ Date: _____

Authorization #: _____