SUBMIT TO
Behavioral Health Prior Authorization FAX 1-844-878-6989
Behavioral Health Concurrent Review FAX 1-844-247-9450
PHONE 1-844-694-6411

univera HEALTHCARE an excellus company

This Form Is For Medicaid Managed Care and HARP Lines of Business Only.

OUTPATIENT TREATMENT REQUEST FORM

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

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID# _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary_____

Tertiary_____

Additional_____

Additional _____

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 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/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 (0) ☐ No (5)
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 of 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 the rules at home or school? ☐ Yes (0) ☐ No (5)
10. In the last 30 days, has your child been placed in state custody (DCFS or Juvenile Justice)? ☐ Yes (5) ☐ No (0)

Adults Only

11. Are you currently employed or attending school? ☐ Yes (5) ☐ No (0)
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	☐	☐	☐	☐	Hyperactivity/Inattn.	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Irritability/Mood Instability	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Hopelessness	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐	Other (include severity):	☐	☐	☐	☐

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐	Drug(s) of Choice:_____				

Last Date of Substance Use:_____

_____Member Name

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 MEASURABLE TREATMENT GOALS

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

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING.	DATE SERVICE: STARTED	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING					
☐ H0040- Assertive Community Treatment (ACT)					
☐ H2012- Continuing Day Treatment (CDT)					
☐ H2012- Intensive Psychiatric Rehabilitative Treatment (IPRT)					
☐ H2019- Personalized Recovery Oriented Services (PROS) Comm Rehab Services 2+ units; Enhanced CRS Contact					
☐ T1015 - Personalized Recovery Oriented Services (PROS) Clinial Treatment Add-On					
☐ H2025- Personalized Recovery Oriented Services (PROS) Ongoing Rehab and Support					
☐ H2018- Personalized Recovery Oriented Services (PROS) Intensive Rehabilitation					

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?

Clinician printed name

Clinician Signature Date

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