



Has a psychiatric evaluation been completed?  YES \_\_\_\_\_ (date)  NO If no, indicate why this has not been completed:

**Substance Abuse**

NONE  BY HISTORY  CURRENT/ACTIVE USE

DRUG	AMOUNT	FREQUENCY	FIRST USE (DATE)	LAST USE (DATE)

Is member attending AA/NA meetings?  YES  NO If yes, how often? \_\_\_\_\_

Current Step: \_\_\_\_\_ Was a sponsor identified?  YES  NO

**Treatment Details**

What therapeutic approach (e.g. evidence-based practice, therapeutic model, etc.) is being utilized with this member?

Are the member's family/supports involved in treatment?  YES  NO If no, why? \_\_\_\_\_

Where are services being provided?  SCHOOL  HOME  OFFICE  OTHER \_\_\_\_\_

What other services are being provided to this member that are not requested in this OTR? Please include frequency:

Is care being coordinated with member's other service providers?  YES  NO  N/A

**Has information been shared with PCP regarding behavioral health provider contact information, presenting problem, date of initial visit, diagnoses, and any meds prescribed?**  YES \_\_\_\_\_ (date)  NO If no, why? \_\_\_\_\_

**Treatment Goals**

Describe measurable goals and treatment plan agreed upon by member.

MEASURABLE GOAL	DATE INITIATED	CURRENT PROGRESS (Please note specific progress made.)

**Treatment Changes**

How has the treatment plan been modified since the last OTR?

**Discharge Criteria**

Objectively describe how it will be known that the member is ready to discontinue treatment.

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
<b>Behavioral Health Outpatient Services:</b> Individual Therapy (billed as CPT codes)					
<b>Behavioral Health Outpatient Services:</b> Family Therapy (billed as CPT codes)					
<b>Behavioral Health Outpatient Services:</b> Group Therapy (billed as CPT codes)					
<p>If you are a <b>nonparticipating provider only</b>, please indicate here any additional codes you are requesting authorization for.</p> <p><b>Other code(s) requested:</b></p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p> <p><input type="checkbox"/> _____</p>					

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**  
 504 Lavaca, Suite 850, Austin, Texas 78701  
 PHONE 800.224.1991 FAX 866.694.3649