



SUBMIT TO
Utilization Management Department
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Texas Outpatient Treatment Request (OTR) Please print clearly. Incomplete or illegible forms will delay processing.

Member Identification

MEMBER NAME _____
 HEALTH PLAN STAR STARPLUS CHIP RSA
 STAR Health (Foster Care) OTHER _____
 DATE OF BIRTH _____
 SS # _____
 MEMBER ID # _____
 LAST AUTH # _____

DSM Axes

Please complete all axes.

AXIS I

 AXIS II

 AXIS III

 AXIS IV

 AXIS V Current _____ Highest in past year _____

Why did the member originally present for treatment?

Current Presentation/Symptoms

Describe the CURRENT situation and symptoms.

Impact on current functioning (occupational, academic, social, etc.)?

	<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE
	<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE
	<input type="checkbox"/> MILD <input type="checkbox"/> MODERATE <input type="checkbox"/> SEVERE

MH/SA Treatment History

What has member received in the past?
 NONE OP MH OP SA IP MH IP SA/DETOX
 OTHER _____
 List approx. dates of each service, including hospitalizations:

Provider Identification

Check AGENCY or PROVIDER to indicate how to authorize.
 AGENCY/GROUP NAME _____
 PROVIDER NAME _____
 PROFESSIONAL CREDENTIALS _____
 ADDRESS/CITY/STATE _____

 PHONE _____ FAX _____
 NPI (required) _____
 TAX ID (required) _____

Current Risk/Lethality

Suicidal
 NONE IDEATION PLAN* MEANS* INTENT*
 Past attempt date(s): _____

Homicidal
 NONE IDEATION PLAN* MEANS* INTENT*
 Past attempt date(s): _____

*Please indicate current safety plans:

Current assaultive/violent behavior, including frequency:

Clearly describe any risk of out-of-home placement and/or risk for higher level of care:

Current Psychotropic Medications

Prescriber: PSYCHIATRIST GENERAL PRACTITIONER
 OTHER _____

MEDICATION NAME	DATE STARTED	COMPLIANT? (Y/N)

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? _____

For foster care members, please report level of care (e.g. basic, moderate, specialized, etc): _____

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
Behavioral Health Outpatient Services: Individual Therapy (billed as CPT codes)					
Behavioral Health Outpatient Services: Family Therapy (billed as CPT codes)					
Behavioral Health Outpatient Services: Group Therapy (billed as CPT codes)					
Alcohol and/or Drug Services: Ambulatory (Outpatient) Detox. (Star/Star+ only) <input type="checkbox"/> H0014 (15 min units)					
Behavioral Health Counseling & Therapy (Star/Star+/Foster Care only) <input type="checkbox"/> H0004 (15 min units)					
Alcohol and/or Drug Services: Group Counseling (Star/Star+/Foster Care only) <input type="checkbox"/> H0005 (1 hour units)					
Skills Training & Development (Chip/RSA/Foster Care only) <input type="checkbox"/> H2014 (15 min units)					
Psychosocial Rehab Services (Chip/RSA/Foster Care only) <input type="checkbox"/> H2017 (15 min units)					
Crisis Intervention (Foster Care only) <input type="checkbox"/> H2011 (15 min units)					
Medication Training & Support (Foster Care only) <input type="checkbox"/> H0034 (15 min units)					
Training & Educational Services (Foster Care only) <input type="checkbox"/> G0177 (per encounter)					
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"/> _____					

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.).