



SUBMIT TO  
Utilization Management Department  
504 Lavaca, Suite 850, Austin, Texas 78701  
PHONE 800.947.0633 FAX 866.694.3649

Georgia Outpatient Treatment Request (OTR) Please print clearly. Incomplete or illegible forms will delay processing.

**Member Identification**

MEMBER NAME \_\_\_\_\_  
HEALTH PLAN \_\_\_\_\_  
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.)?

MILD  MODERATE  SEVERE  
 MILD  MODERATE  SEVERE  
 MILD  MODERATE  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? \_\_\_\_\_

**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: (billed as CPT codes) <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Family Therapy <input type="checkbox"/> Group Therapy					
Group/Family Psychotherapy <input type="checkbox"/> H0004 (15 min units)					
Ambulatory Detox <input type="checkbox"/> H0014 (15 min units)					
Intensive Family Intervention <input type="checkbox"/> H0036 (15 min units)					
Adult Peer Supports <input type="checkbox"/> H0038 (15 min units)					
Assertive Community Therapy <input type="checkbox"/> H0039 (15 min units)					
Residential Services <input type="checkbox"/> H0043 (per diem)					
Crisis Management <input type="checkbox"/> H2011 (15 min units)					
Family/Group Skills Training <input type="checkbox"/> H2014 (15 min units)					
Community Support <input type="checkbox"/> H2015 (15 min units)					
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"/> _____ <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 \_\_\_\_\_