Cenpatico
Improving Lives.

SUBMIT TO
Utilization Management Department
504 Lavaca, Suite 850, Austin, Texas 78701
PHONE 800.589.3186 FAX 866.694.3649

Wisconsin 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?

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 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:

Current Psychotropic Medications

Prescriber: ☐ PSYCHIATRIST ☐ GENERAL PRACTITIONER
☐ OTHER ____________________

MEDICATION NAME	DATE STARTED	COMPLIANT? (Y/N)

Member Name

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.

_______________________ Member Name

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 Drug Service: Group Counseling ☐ H0005 (1 hour units)					
Alcohol and Drug Intervention Services ☐ H0022 (1 hour units)					
Alcohol and Drug Abuse Services ☐ H0047 (1 hour units)					
Alcohol/substance abuse services, family/couple counseling ☐ T1006 (1 hour units)					
If you are a nonparticipating provider only, please indicate here any additional codes you are requesting authorization for. Other code(s) requested: ☐ ____________________ ☐ ____________________ ☐ ____________________ ☐ ____________________					

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.).

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