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SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
Phone: 1.877.658.0305 FAX 1.866.694.3649

Outpatient Treatment Request (OTR) Form

Please write clearly and only in designated areas. 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 # _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary _____

Tertiary _____

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/your child had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you/your child 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 (5) ☐ No (0)
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 out the home?
   ☐ Yes (5) ☐ No (0)
8. Do you/your child 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 (5) ☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)? ☐ Yes (5) ☐ No (0)

Adults Only

11. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
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
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Hyperactivity/Inattn.	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS *(If present, check degree to which it impacts daily functioning.)*

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐

Last Date of substance use: _____

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐

Drug(s) of Choice: _____

Member Name _____

RISK ASSESSMENT

Suicidal:	☐ None	☐ Ideation	☐ Planned	☐ Imminent Intent	☐ History of self-harming behavior
Homicidal:	☐ None	☐ Ideation	☐ Planned	☐ Imminent Intent	☐ History of self-harming behavior
Safety Plan in place? (If plan or intent indicated):			☐ Yes	☐ No	
If prescribed medication, is member compliant?			☐ Yes	☐ No	

CURRENT MEASUREABLE TREATMENT GOALS

REQUESTED AUTHORIZATION *(please check off appropriate box to indicate modifier, if applicable.)*

Behavioral Health Outpatient Services	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
☐ Individual Therapy				
☐ Group Therapy				
☐ Family Therapy				

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 Signature _____

Date _____

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

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Have any questions?
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