Cenpatico® Improving Lives

ABSOLUTE TOTAL CARE TOTAL | Healthy Connections PRIME

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

MEMBER INFORMATION

Member Name____

Health Plan ____

DOB ____

SS #____

Member ID # ____

Last Auth #____

PROVIDER INFORMATION

Provider Name (print) __________________________________

Provider/Agency Tax ID #__________________________________

Provider/Agency NPI Sub Provider #________________________

Phone ____________________ Fax ____________________

CURRENT ICD DIAGNOSIS

Primary____

Secondary____

Tertiary____

Additional____

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 had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you had problems with fears and anxiety? ☐ Yes (5) ☐ No (0)
3. Do you 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? ☐ Yes (5) ☐ No (0)
5. In the last 30 days, have you gotten in trouble with the law? ☐ Yes (5) ☐ No (0)
6. In the last 30 days, have you 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 had trouble getting along with other people including family and people out of the home?
   Yes (5) ☐ No (0) ☐
8. Do you feel optimistic about the future? ☐ Yes (0) ☐ No (5)
9. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
10. 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

	N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐

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

Other (include severity):__________________________________

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

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

Last Date of substance use:________________________

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

Drug(s) of Choice:__________________________________

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 MEASURABLE TREATMENT GOALS

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

SERVICE	DATE SERVICE STARTED	FREQUENCY: How Often Seen	INTENSITY: # of Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
NON-PARTICIPATING PROVIDERS ONLY					
Psychiatric Diagnostic Evaluation (1 unit per 6 months) ☐ 90791 ☐ 90792					
Mental Health Comprehensive Diagnostic ☐ H2000 (Encounter per 6 months) ☐ H0031 (12 encounters per year)					
Behavioral Health Screening (15 min=1 unit) ☐ H0002					
Behavioral Health Outpatient Services: Individual Therapy (billed as CPT codes; 1 unit per day) ☐ 90832 ☐ 90834 ☐ 90837 ☐ 90833 ☐ 90836 ☐ 90838 ☐ 90845 ☐ 90785 (Interactive Complexity add on code)					
Behavioral Health Outpatient Services: Family Therapy (billed as CPT codes; 1 unit per day) ☐ 90846 ☐ 90847					
Behavioral Health Outpatient Services: Group Therapy (billed as CPT codes; 1 unit per day) ☐ 90846 ☐ 90846					
Team Conference (6 encounters per rolling 12 months) ☐ 99366 ☐ 99367					
Mental Health Service Plan Development ☐ H0032 (15 min units)					
Medical Evaluation and Management ☐ 90836 (Encounter = 1 unit)					
Office Visit(Maximum of 1unit per day; 1unit=day) ☐ 99201 ☐ 99202 ☐ 99204 ☐ 99205 ☐ 99211 ☐ 99212 ☐ 99214 ☐ 99215					
Nursing Facility Care- Subsequent ☐ 99307 ☐ 99308 ☐ 99309 ☐ 99310					

PARTICIPATING AND NON-PARTICIPATING PROVIDERS					
Vivtrol Injection (1 unit = 1 per month; billed in conjunction with 96372) ☐ J2315					
Targeted Care Management (15 minutes = 1 unit; Max 16 units per day; Authorization required after 200 units for Participating Providers.) ☐ T1017					
Concurrent Case Management (15 minutes = 1 unit; Max 16 units per day; Authorization required after 200 units for Participating Providers.) ☐ T1016					
IF YOU ARE A NON-PARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR. OTHER CODE(S) REQUESTED:					
☐					
☐					
☐					
☐					

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?

Standard Review:

Standard 14-day time frame will be applied.

Clinician Signature Date

Expedited Review:

By signing below, I certify that applying the standard 14-day time frame could seriously jeopardize the member's health, life or ability to regain maximum function.

Clinician Signature Date

SUBMIT TO

Utilization Management Department

12515-8 Research Blvd., Suite 400

Austin, Texas 78759

PHONE 1.855.735.4398| FAX 1.877.725.7751