magnolia health
Mississippi Children's Health Insurance Program

Cenpatico
Improving Lives

SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
PHONE 866.912.6285 | FAX 866.694.3649

OUTPATIENT TREATMENT REQUEST FORM

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

Date____

MEMBER INFORMATION

Name____
DOB ____
Member ID #_______________________________________
Health Plan_______________________________________

PROVIDER INFORMATION

Provider Name (print) ______________________________
Provider/Agency Tax ID #____________________________
Provider/Agency NPI Sub Provider #___________________
Phone ____________________ Fax ____________________

DSM-IV TR DIAGNOSIS

AXIS I ____
AXIS II ____
AXIS III ____
AXIS IV ____
AXIS V ____

Has contact occurred with PCP? ☐ Yes ☐ No

Date first seen by provider/agency___________________
Date last seen by provider/agency___________________
SPMI/SED ☐ Yes ☐ No

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 the home?
   ☐ Yes (5) ☐ No (0)
8. Do you feel optimistic about the future? ☐ Yes (0) ☐ No (5)
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 (DCYF or DJJ)? ☐ 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	☐	☐	☐	☐

Other (include severity): ____________________________

FUNCTIONAL IMPAIRMENT (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 harm to others
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.)

	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
CMHC OUTPATIENT SERVICES				
Authorization Required for all Providers				
☐ H2030 Psychosocial Rehab (15 min units)				
☐ H0036 Community Support Services (15 min units)				
☐ H0039 Assertive Community Treatment (15 min units)				
☐ H2021 Wraparound Facilitation (15 min units)				
Non-Participating Providers are required to receive authorization prior to rendering any CHIP services. Please indicate here any codes you are requesting authorization for. Other code(s) requested:				
☐				
☐				
☐				
☐				
☐				

PARTIAL HOSPITALIZATION PROGRAMS (H0035) AND CRISIS RESIDENTIAL (T2048) BOTH REQUIRE A LIVE REVIEW WITHIN 24 HOURS OF ADMISSION. CALL 866.912.6285.

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?

What other services are being provided to this member that are not requested in this OTR? Please include frequency:

Provider Name Provider 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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