SUBMIT TO
Utilization Management Department
12515-8 Research Blvd., Suite 400
Austin, Texas 78759
Phone: 800-589-3186 FAX 1.866.694.3649

MyCareOhio *Connecting Medicare + Medicaid* | buckeye health plan | enpatico Improving Lives

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – 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 #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

*Primary_____

Secondary_____

Tertiary_____

Additonal_____

Additonal_____

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 outside 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

Treatment Plan Changes

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/Inattn.	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐

Risk of OHH Placement :_____

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:_____

Attending AA/NA: ☐ Yes ☐ No

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.)

SERVICE	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
BEHAVIORAL HEALTH OUTPATIENT SERVICES: PLEASE REVIEW THE ESTABLISHED ANNUAL BENEFIT LIMITS PROVIDED IN THE PROVIDER MANUAL (BILLED AS CPT CODES)				
☐ Ambulatory Detox H0014				
☐ Assessment SUD H0001				
☐ Alcohol/ Drug Screen Urinalysis H003				
☐ Behavioral Health Counseling Therapy Individual or Group (15 minunits) H0004				
☐ Case Management H0006 (1hr units)				
☐ Crisis Intervention S9484, H0007(1hr Units)				
☐ Community Psychiatric - Individual or Group H0036(15min units)				
☐ Medical/Somatic H0016				
☐ Mental Health Assessment- 90792, H0031				
☐ Methadone Administration H0020				
☐ Pharmacologic Management 90836				
☐ Psychological Rehab H2017(15 min units) H2018 (per day)				
☐ Recovery Management (RM) T1016				
☐ Peer Recovery Support (PRS) H0038				
☐ Individualized Placement and Support - Supported Employment (IPS-SE) - Initial Visit H2023				
☐ Individualized Placement and Support - Supported Employment (IPS-SE) Ongoing Visits H2025				
NON-PARTICIPATING PROVIDER- PRIOR AUTHORIZATION MUST BE REQUESTED FOR ALL SERVICES NOT COVERED UNDER THE TRANSITION OF CARE.				
Please write in the service you are requesting to provide :				
☐				
☐				
☐				

STANDARD REVIEW: STANDARD 14-DAY TIME FRAME WILL BE APPLIED.

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.

Provider Signature _____ Date _____

Provider Signature _____ Date _____

Cenpatico is Buckeye Health Plan's MyCare Ohio (a Medicare-Medicaid Plan) behavioral health affiliate. Buckeye has delegated managing the provision of covered mental health and substance use disorder services to Cenpatico.

Have Questions?
Call us at 1-866-549-8289

www.cenpatico.com