



Submit to:

HHW OUTPATIENT TREATMENT REQUEST (OTR)

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

<p><u>Member Information</u></p> <p>Patient Name: _____</p> <p>Health Plan: _____</p> <p>DOB: _____</p> <p>SS#: _____</p> <p>Patient ID#: _____</p> <p>Last Auth. #: _____</p>	<p><u>Provider Information</u> (Please indicate by checking below, whether requested services should be authorized to the provider or agency.)</p> <p>____ Provider Name (print): _____</p> <p>Professional Credential: ___ MD ___ PhD ___ Other _____</p> <p>____ Group/Agency Name: _____</p> <p>Physical Address: _____ (street address, city, state, zip)</p> <p>Phone: _____ Fax: _____</p> <p>Medicaid/TPI/NPI #: _____ Tax ID # _____</p>																												
<p><u>Previous BH/SA Treatment</u></p> <p><input type="checkbox"/> None or <input type="checkbox"/> OP <input type="checkbox"/> MH <input type="checkbox"/> SA and/or <input type="checkbox"/> IP <input type="checkbox"/> MH <input type="checkbox"/> SA</p> <p>List names & dates, include hospitalizations: _____</p> <p>_____</p> <p>Substance Abuse: <input type="checkbox"/> None <input type="checkbox"/> By History and/or <input type="checkbox"/> Current/Active</p> <p>Substance(s) used, amount, frequency & last used: _____</p> <p>_____</p> <p>DSM IV Axis:</p> <p>AXIS I _____</p> <p>AXIS II _____</p> <p>AXIS III _____</p> <p>AXIS IV _____</p> <p>AXIS V _____ CURRENT _____ PAST YEAR _____</p>	<p><u>Treatment Goals</u></p> <p>List primary complaint/problem to be addressed: _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><u>Discharge Criteria</u></p> <p>Objectively describe how you will know that the patient is ready to discontinue treatment: _____</p> <p>_____</p> <p>_____</p> <p>Please answer YES or NO to the following questions:</p> <p>Are the Member's family/supports involved in treatment? _____</p> <p>Coordination of care with other behavioral health providers? _____</p> <p>Coordination of care with medical providers? _____</p> <p>Has Member been evaluated by a Psychiatrist? _____</p>																												
<p><u>Primary Medical Physician (PMP) Communication</u></p> <p>Has information been shared with the PMP regarding:</p> <ul style="list-style-type: none"> • The initial evaluation & treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No • This updated evaluation & treatment plan <input type="checkbox"/> Yes <input type="checkbox"/> No <p>PMP Name/Date <u>last</u> notified: _____</p> <p>If No, explain: _____</p> <p>_____</p>	<p><u>Current Risk/Lethality</u></p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;">Suicidal</td> <td style="padding: 2px;"><input type="checkbox"/> 1 NONE</td> <td style="padding: 2px;"><input type="checkbox"/> 2 LOW</td> <td style="padding: 2px;"><input type="checkbox"/> 3 MOD*</td> <td style="padding: 2px;"><input type="checkbox"/> 4 HIGH*</td> <td style="padding: 2px;"><input type="checkbox"/> 5 EXTREME*</td> </tr> <tr> <td style="padding: 2px;">Homicidal</td> <td style="padding: 2px;"><input type="checkbox"/> 1 NONE</td> <td style="padding: 2px;"><input type="checkbox"/> 2 LOW</td> <td style="padding: 2px;"><input type="checkbox"/> 3 MOD*</td> <td style="padding: 2px;"><input type="checkbox"/> 4 HIGH*</td> <td style="padding: 2px;"><input type="checkbox"/> 5 EXTREME*</td> </tr> <tr> <td style="padding: 2px;">Assault/ Violent Behavior</td> <td style="padding: 2px;"><input type="checkbox"/> 1 NONE</td> <td style="padding: 2px;"><input type="checkbox"/> 2 LOW</td> <td style="padding: 2px;"><input type="checkbox"/> 3 MOD*</td> <td style="padding: 2px;"><input type="checkbox"/> 4 HIGH*</td> <td style="padding: 2px;"><input type="checkbox"/> 5 EXTREME*</td> </tr> </table> <p><u>Progress/Compliance</u></p> <p>*Overall Progress toward goal:</p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;"><input type="checkbox"/> 1 NONE*</td> <td style="padding: 2px;"><input type="checkbox"/> 2 MIN*</td> <td style="padding: 2px;"><input type="checkbox"/> 3 MOD</td> <td style="padding: 2px;"><input type="checkbox"/> 4 MAX</td> <td style="padding: 2px;"><input type="checkbox"/> 5 MET</td> </tr> </table> <p>*Compliance with treatment:</p> <table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr> <td style="padding: 2px;"><input type="checkbox"/> 1 NONE*</td> <td style="padding: 2px;"><input type="checkbox"/> 2 MIN*</td> <td style="padding: 2px;"><input type="checkbox"/> 3 MOD</td> <td style="padding: 2px;"><input type="checkbox"/> 4 MAX</td> <td style="padding: 2px;"><input type="checkbox"/> 5 MET</td> </tr> </table> <p>Medical Psychiatric Eval done? (even if PMP providing meds) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Medication given by <input type="checkbox"/> Psychiatrist <input type="checkbox"/> PMP <input type="checkbox"/> N/A</p> <p>Current Risk/Lethality *3-5, Progress/Compliance *1-2 checked, give intervention: _____</p> <p>_____</p> <p>Provider Signature/Date: _____</p>	Suicidal	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*	Homicidal	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*	Assault/ Violent Behavior	<input type="checkbox"/> 1 NONE	<input type="checkbox"/> 2 LOW	<input type="checkbox"/> 3 MOD*	<input type="checkbox"/> 4 HIGH*	<input type="checkbox"/> 5 EXTREME*	<input type="checkbox"/> 1 NONE*	<input type="checkbox"/> 2 MIN*	<input type="checkbox"/> 3 MOD	<input type="checkbox"/> 4 MAX	<input type="checkbox"/> 5 MET	<input type="checkbox"/> 1 NONE*	<input type="checkbox"/> 2 MIN*	<input type="checkbox"/> 3 MOD	<input type="checkbox"/> 4 MAX	<input type="checkbox"/> 5 MET
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<p><u>Requested Authorization</u></p> <p>Services requested: <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Family <input type="checkbox"/> Med Management</p> <p style="padding-left: 40px;"><input type="checkbox"/> ECT (Call Medical Management to discuss request)</p> <p>Total sessions requested this OTR: _____</p> <p>Frequency of visits: _____</p> <p>CPT codes: _____</p> <p>Est. # of sessions to complete treatment episode: _____</p> <p>Requested start date for authorization: _____</p>																													