



**MEMBER INFORMATION**

Patient Name \_\_\_\_\_  
 Health Plan \_\_\_\_\_  
 DOB \_\_\_\_\_  
 Medicaid RID # \_\_\_\_\_  
 Last Authorization # \_\_\_\_\_

**PROVIDER INFORMATION**

Provider Name \_\_\_\_\_  
 Provider Credential MD \_\_\_\_\_ PHD \_\_\_\_\_ OTHER \_\_\_\_\_  
 Group / Agency Name \_\_\_\_\_  
 Physical Address \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Facsimile Number \_\_\_\_\_  
 Medicaid / TPI / NPI # \_\_\_\_\_ Tax ID # \_\_\_\_\_  
 Please indicate to whom the authorization should be made Individual Provider (Y/N) \_\_\_\_\_ Group / Facility (Y/N) \_\_\_\_\_ Place of Service \_\_\_\_\_

**PREVIOUS BH/SA TREATMENT**  None or  OP  MH  SA and/or  IP  MH  SA

List names / dates including hospitalizations if applicable: \_\_\_\_\_

**Substance Abuse:**  None  By History and/or  Current/Active **Tobacco Abuse:**  None  By History and/or  Current/Active

Substance(s) used, amount, frequency & last used: \_\_\_\_\_

**DSM IV Axis:** (Please include relevant medical conditions on Axis III)

AXIS I \_\_\_\_\_  
 AXIS II \_\_\_\_\_  
 AXIS III \_\_\_\_\_  
 AXIS IV \_\_\_\_\_  
 AXIS V \_\_\_\_\_ CURRENT \_\_\_\_\_ PAST YEAR \_\_\_\_\_

If the Member has a substance use and / or HIV diagnosis, has a consent to release information for these related conditions been obtained?

Yes  No  N/A

**Primary Medical Physician (PMP) Communication**

Has information been shared with the PMP regarding:

- The initial evaluation & treatment plan?  Yes  No
- This updated evaluation & treatment plan  Yes  No

PMP Name/Date last notified: \_\_\_\_\_

If No, explain: \_\_\_\_\_

**Current Risk/Lethality**

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*

**Current Risk/Lethality \*2-5, Progress/Compliance \*1-2 checked, give intervention:** \_\_\_\_\_

**Please answer YES or NO to the following questions:**

Is Member currently participating in any community based support groups / interventions? \_\_\_\_\_

Are the Member's family/supports involved in treatment? \_\_\_\_\_

Coordination of care with other behavioral health providers? \_\_\_\_\_

Coordination of care with medical providers? \_\_\_\_\_

Has Member been evaluated by a Psychiatrist? \_\_\_\_\_

Is this Member currently receiving Medicaid Rehabilitation Option Services? (If yes, please describe)

**Treatment Goals**

List primary complaint / problem to be addressed: \_\_\_\_\_

List measureable treatment goals: \_\_\_\_\_

**Discharge Goals**

Objectively describe how you will know the patient is ready to discontinue treatment: \_\_\_\_\_

**\*Overall Progress toward goal:**

<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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**\*Compliance with treatment:**

<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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Medical Psychiatric Eval done? (even if PMP providing meds)  Yes  No

Medication given by  Psychiatrist  PMP  N/A

**Requested Authorization: Services Requested:** Individual  Group  Family  Med Management  ECT (Call Medical Management)

**Total sessions requested:** \_\_\_\_\_ **Frequency of visits:** \_\_\_\_\_ **CPT Codes:** \_\_\_\_\_

Estimated # of sessions to complete treatment episode: \_\_\_\_\_ Requested Start Date: \_\_\_\_\_

Provider Signature/ Date: \_\_\_\_\_