Outpatient Treatment Request Form

Use to request Crisis Services

Please print clearly—incomplete or illegible forms may delay processing.

Instructions

Submit these documents:

- ☐ This Outpatient Treatment Request form
- ☐ Treatment Plan or Initial Treatment Goals
- ☐ Complete all questions in entirety to prevent a delay in processing or an adverse determination

By fax to:

1-833-592-0657

Provider Information

Clinician:_____ Credentials: _____

Agency Name:_____

Agency Phone:_____ Agency Secure Fax:_____

Agency NPI:_____ Agency TIN: _____

Agency Address:_____

City: _____ State: _____ Zip:_____

Member Information

First Name:_____ Last Name: _____

Medicaid ID:_____ Birth Date:_____

Primary Diagnosis ICD-10 Code:_____

Additional:_____

Co-morbid Medical Diagnosis ICD-10 Code:_____

Has contact occurred with PCP? ☐ YES ☐ NO

Is the member compliant with the current medications? ☐ YES ☐ NO

Current Behavioral Health Medications:

_____

Medical Conditions:_____

Anticipated Discharge Date:_____

(If the member requires ongoing support at a lower level of care, the member should return to existing services with current behavioral health provider as soon as indicated and accessible.)

Requested Authorization

Please mark appropriate code(s) in the left column.

PROCEDURE CODES	REQUESTED START DATE MM/DD/YYYY	REQUESTED END DATE MM/DD/YYYY	TOTAL NUMBER OF UNITS REQUESTED	NUMBER OF VISITS PER WEEK
Community Brief Crisis Support (age 21 and greater) ☐ H2011/HK				
Mobile Crisis-Telehealth (Requires Notification) ☐ H2011 TG/95				
Mobile Crisis Response - Initial Contact ☐ S9485 TG/U8				
Mobile Crisis Response - Community Based Follow Up ☐ H2011 TG/U8				
Behavioral Health Crisis Care less than 4 hrs/licensed staff (Requires Notification) ☐ S9484/TG				
Behavioral Health Crisis Care less than 4 hrs/non-licensed staff (Requires Notification) ☐ S9484/HK				
Behavioral Health Crisis Care greater than 4 hrs/non licensed staff (Requires Notification) ☐ S9485/HK				
Behavioral Health Crisis Care greater than 4 hrs/licensed staff (Requires Notification) ☐ S9485/TG				
Crisis Stablization Per Diem (# of days) (Requires Notification) ☐ H0045/TG			**N/A**	**N/A**

FUNCTIONAL OUTCOMES (choose yes or no)

In the last 30 days, has member been in crisis?	☐ YES	☐ NO
In the last 30 days, has member received inpatient or residential behavioral health care?	☐ YES	☐ NO
In the last 30 days, has the member had problems with sleeping or feeling sad?	☐ YES	☐ NO
In the last 30 days, has the member had problems with had problems with fears and anxiety?	☐ YES	☐ NO
In the last 30 days, has alcohol or drug use caused problems for member?	☐ YES	☐ NO
In the last 30 days, has member gotten in trouble with the law?	☐ YES	☐ NO
In the last 30 days, has member had trouble getting along with other people including family and people out the home?	☐ YES	☐ NO
In the last 30 days, has member had an unstable living situation?	☐ YES	☐ NO

CHILDREN ONLY

In the last 30 days, has member been suspended or expelled from school?	☐ YES	☐ NO
Is member currently in state custody (DCFS or Juvenile Justice)?	☐ YES	☐ NO

ADULTS ONLY

Is member currently employed or attending school?	☐ YES	☐ NO

SYMPTOMS (IF PRESENT, SELECT DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Social Withdrawal	☐	☐	☐	☐
Hallucinations/Delusions	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Hyperactivity	☐	☐	☐	☐
Inattention	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Violent Outbursts/Anger	☐	☐	☐	☐
Personal Distress	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT (IF PRESENT, SELECT DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
Personal Hygiene	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Medication Compliance	☐	☐	☐	☐
Substance Use (Current)	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Intoxication or Withdrawal	☐	☐	☐	☐

List Substance Used: _____

CURRENT RISK ASSESSMENT (select all that apply)

Suicidal: ☐ None ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ Self Injury

History of self-harming behavior (dates)_____

Homicidal: ☐ None ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ Self Injury

History of harm to others (dates)_____

Safety Plan in place? (**If plan or intent indicated attach recent crisis plan**) ☐ Yes ☐ No

Describe any recent crisis:

_____

TREATMENT GOALS, PROGRESS, AND BARRIERS

TREATMENT GOALS	SPECIFIC PROGRESS MADE:	CONTINUED BARRIERS TO GOAL ATTAINMENT:
Goal 1:		
Goal 2:		
Goal 3:		
Goal 4:		

Describe presenting problems related to urgent mental health distress of member.

Please indicate if member has been referred from CBCS (COMMUNITY BRIEF CRISIS SUPPORT)

☐ Yes ☐ No

If this is a re-authorization, please provide a brief narrative expressing the success or lack of success during the previous authorization period.

Describe what worked for the member, what did not work for the member, and how member's symptoms specifically continue to impair functioning.

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

Clinician printed name with Credentials: **Date**

_____ _____

Clinician Signature with Credentials:

_____

Once completed,
Fax to: 1-888-725-0101