OUTPATIENT TREATMENT REQUEST FORM

Use to request ACT, FFT, FFT-CW, Homebuilders, MST, Psychotherapy Services, Individual Placement and Support, and Crisis Intervention Follow-up Services

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

Instructions

Submit these documents:

- This Outpatient Treatment Request form
- LOCUS/CALOCUS Assessment (completed within last 180 days)
- Treatment Plan or Initial Treatment Goals
- Healthy Louisiana Behavioral Health Assessment (annually)
- Ensure to complete all questions in entirety to prevent a delay in processing or an adverse determination

By fax to:

1-888-725-0101

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 ☐

Does member participate in medical management? Yes ☐ No ☐

Current Behavioral Health Medications: _____

Medical Conditions:_____

REQUESTED AUTHORIZATION (please mark appropriate code(s) in the left column)

	PLEASE INDICATE IN THE LEFT COLUMN WHICH CODES YOU ARE REQUESTING	Requested Start Date	Requested End Date	Total Number of Units Requested	Number of Visits per Week
☐	Community Psychiatric Supportive Treatment				
☐	H0036 HK Homebuilders				
☐	H0036 HE Functional Family Therapy				
☐	H0036 HE Functional Family Therapy Child Welfare (FFT-CW)				
☐	Assertive Community Treatment Program (ACT) H0039				
☐	Multisystemic Family Therapy H2033				
☐	Individual Placement and Support H2024				
☐	Crisis Intervention follow up H2011 (no modifier)				

PRIOR AUTHORIZATION FOR PSYCHOTHERAPY CODES (to be used AFTER Member has used 24 sessions that do not require a PA)

	PLEASE INDICATE IN THE LEFT COLUMN WHICH CODES YOU ARE REQUESTING	Requested Start Date	Requested End Date	Total Number of Visits Requested (not to exceed 12)	Number of Visits per Week
☐	90832 Psychotherapy 30 min. with patient and/or family member				
☐	90833* Psychotherapy 30 min. with patient with patient and/or familymember when performed with an E/M service				
☐	90834 Psychotherapy 45 min. with patient and/or family member				
☐	90836* Psychotherapy 45 min. with patient and/or family member when performed with an E/M service				
☐	90837 Psychotherapy 60 min. with patient and/or family member				
☐	90838* Psychotherapy 60 min. with patient and/or family member when performed with E/M service				
☐	90840 Psychotherapy for Crisis each additional 30 min				

☐	90847 Family Psychotherapy conjoint psychotherapy; with patient present				
☐	90849 Multiple Family Group Psychotherapy				
☐	90853 Group Psychotherapy other than of a multiple family group				
☐	90845 Psychoanalysis				
☐	90875 Individual Therapy with Biofeedback 30 min.				
☐	90876 Individual Therapy with Biofeedback 60 min				

FUNCTIONAL OUTCOMES (choose yes or no)

1. In the last 30 days, has member been in crisis? Yes ☐ No ☐
2. In the last 30 days, has member received inpatient or residential behavioral health care? Yes ☐ No ☐
3. In the last 30 days, has the member had problems with sleeping or feeling sad? Yes ☐ No ☐
4. In the last 30 days, has the member had problems with had problems with fears and anxiety? Yes ☐ No ☐
5. In the last 30 days, has alcohol or drug use caused problems for member? Yes ☐ No ☐
6. In the last 30 days, has member gotten in trouble with the law? Yes ☐ No ☐
7. In the last 30 days, has member had trouble getting along with other people including family and people out the home? Yes ☐ No ☐
8. In the last 30 days, has member had an unstable living situation? Yes ☐ No ☐

CHILDREN ONLY

9. In the last 30 days, has member been suspended or expelled from school? Yes ☐ No ☐
10. Is member currently in state custody (DCFS or Juvenile Justice)? Yes ☐ No ☐

ADULTS ONLY

11. Is member currently employed or attending school? Yes ☐ No ☐
12. Has Member recently transitioned from a nursing facility or been diverted from nursing facility level of care through the My Choice Louisiana program? Yes ☐ No ☐

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐	Hyperactivity	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Inattention	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐	Mood Swings	☐	☐	☐	☐
Social Withdrawal	☐	☐	☐	☐	Outbursts/Anger	☐	☐	☐	☐

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Personal Hygiene	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Medication Compliance	☐	☐	☐	☐	Relationships	☐	☐	☐	☐
Substance Use (Current)	☐	☐	☐	☐					

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 ☐ Injury to others

History of harm to others (dates)_____

Safety Plan in place? Yes ☐ No ☐

Describe any recent crisis:

TREATMENT GOALS, PROGRESS, AND BARRIERS

Goal 1:	Specific Progress Made:	Continued Barriers to Goal Attainment:
Goal 2:	Specific Progress Made:	Continued Barriers to Goal Attainment:
Goal 3:	Specific Progress Made:	Continued Barriers to Goal Attainment:
Goal 4:	Specific Progress Made:	Continued Barriers to Goal Attainment:

Describe presenting problems.

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**: Date

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