

HHW / HIP OUTPATIENT TREATMENT REQUEST (OTR)

Please print clearly – incomplete or illegible forms will delay processing



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) _____

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: _____