ambetter. FROM silversummit healthplan

SUBMIT TO:
Utilization Management Department
PHONE 1.844.265.1278 FAX 1.844.699.9168

OUTPATIENT TREATMENT REQUEST FORM

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

Date _____

MEMBER INFORMATION

First Name _____

Last Name _____

DOB _____

Member ID # _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID # _____

Provider/Agency NPI Sub Provider # _____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary (Required) _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with PCP? ❑ Yes ❑ No

Date first seen by provider/agency _____

Date last seen by provider/agency _____

SPMI/SED ❑ Yes ❑ No

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT.)

1. In the last 30 days, have you had problems with sleeping or feeling sad?	❑ Yes (5)	❑ No (0)
2. In the last 30 days, have you had problems with fears and anxiety?	❑ Yes (5)	❑ No (0)
3. Do you currently take mental health medicines as prescribed by your doctor?	❑ Yes (0)	❑ No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you?	❑ Yes (5)	❑ No (0)
5. In the last 30 days, have you gotten in trouble with the law?	❑ Yes (5)	❑ No (0)
6. In the last 30 days, have you actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?	❑ Yes (0	❑ No (5)
7. In the last 30 days, have you had trouble getting along with other people including family and people outside the home?	❑ Yes (5)	❑ No (0)
8. Do you feel optimistic about the future?	❑ Yes (0)	❑ No (5)
Children Only:		
9. In the last 30 days, has your child had trouble following rules at home or school?	❑ Yes (5)	❑ No (0)
10. In the last 30 days, has your child been placed in state custody (DCBS or DJJ)?	❑ Yes (5)	❑ No (0)
Adults Only:		
11. Are you currently employed or attending school?	❑ Yes (0)	❑ No (5)
12. In the last 30 days, have you been at risk of losing your living situation?	❑ Yes (5)	❑ No (0)

Therapeutic Approach/Evidence Based Treatment Used _____

LEVEL OF IMPROVEMENT TO DATE

❑ Minor ❑ Moderate ❑ Major ❑ No progress to date ❑ Maintenance treatment of chronic condition

Barriers to Termination

_____

_____

Treatment Plan Changes

_____

_____

Member Name _____

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	❑	❑	❑	❑	Hyperactivity/Inattn.	❑	❑	❑	❑
Decreased Energy	❑	❑	❑	❑	Irritability/Mood Instability	❑	❑	❑	❑
Delusions	❑	❑	❑	❑	Impulsivity	❑	❑	❑	❑
Depressed Mood	❑	❑	❑	❑	Hopelessness	❑	❑	❑	❑
Hallucinations	❑	❑	❑	❑	Other Psychotic Symptoms	❑	❑	❑	❑
Angry Outbursts	❑	❑	❑	❑	Other (include severity):_____				
					Risk of OOH Placement	❑	❑	❑	❑

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	❑	❑	❑	❑	Physical Health	❑	❑	❑	❑
Relationships	❑	❑	❑	❑	Work/School	❑	❑	❑	❑
Substance Use	❑	❑	❑	❑	Drug(s) of Choice _____				
Last Date of substance use: _____					Attending AA/NA	❑ Yes	❑ No		

RISK ASSESSMENT

Suicidal	❑ None	❑ Ideation	❑ Planned	❑ Imminent Intent	❑ History of self-harming behavior
Homicidal	❑ None	❑ Ideation	❑ Planned	❑ Imminent Intent	❑ History of harm to others
Safety Plan in place? (If plan or intent indicated):			❑ Yes	❑ No	
Medical Psychiatric Evaluation completed?			❑ Yes	❑ No	
If prescribed medication, is member compliant?			❑ Yes	❑ No	

CURRENT MEASUREABLE TREATMENT GOALS

Optional: Please provide a narrative or any additional documentation you feel will support this request.

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

SERVICE Behavioral Health Outpatient Services	FREQUENCY How Often Seen	INTENSITY # Units Per Visit	REQUESTED START Date for this Auth	ANTICIPATED COMPLETION Date of Service
❑ Individual Psychotherapy — Mental Health				
❑ Individual Psychotherapy — Substance Use Disorder				

Clinician Printed Name _____ Date _____

Clinician Signature _____ Date _____

AMB 18-CE-NV-825486

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