

Behavioral Health Outpatient Treatment Request Form

Please print clearly — incomplete or illegible forms will delay processing. Please fax to: AmeriHealth Caritas Louisiana BH UM at **1-855-301-5356**. For assistance contact: **1-855-285-7466**.

Member information	
Patient name:	Date of birth:
Medicaid/health plan number:	Last authorization number (if applicable):

Provider information		
Provider name:	<input type="checkbox"/> PAR <input type="checkbox"/> NON PAR <input type="checkbox"/> In credentialing process	
Group/agency name:	Provider credential: <input type="checkbox"/> MD <input type="checkbox"/> PhD <input type="checkbox"/> LMHP <input type="checkbox"/> LAC <input type="checkbox"/> NP <input type="checkbox"/> Other, please specify:	
Physical address:	Telephone number:	Fax number:
Medicaid/Provider/NPI #:	Contact name:	

Previous or current BH/SA treatment: None or OPT: MH/SA SA IOP MH/SA Residential PSR
 CPST: (ACT, MST, FFS, CPST, HB) Respite care Therapeutic group home (TGH) Other

Provide specifics: _____

Substance abuse: <input type="checkbox"/> None <input type="checkbox"/> By history or <input type="checkbox"/> Current/active	Tobacco abuse: <input type="checkbox"/> None <input type="checkbox"/> By history or <input type="checkbox"/> Current/active	Gaming abuse: <input type="checkbox"/> None <input type="checkbox"/> By history or <input type="checkbox"/> Current/active
Substance(s) used, amount, frequency and last used: _____		
Previous or current waiver services: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, give specifics: _____		
DSM diagnosis: Primary DX _____ Secondary DX _____ Medical DX _____		
If the member has a substance abuse and/or HIV diagnosis, has a consent to release information for these related conditions been obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		



Primary medical physician (PMP) and other communication: Has information been shared, to the extent permissible, with the PMP/other providers regarding:

1. The initial evaluation and treatment plan? Yes No
2. The updated evaluation and treatment plan? Yes No

Other behavioral health providers names and last notified: _____

PMP name and date last notified: _____

If no, please explain: _____

Current risk/lethality					
Suicidal	<input type="checkbox"/> 1 none	<input type="checkbox"/> 2 low	<input type="checkbox"/> 3 moderate	<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 moderate	<input type="checkbox"/> 4 high	<input type="checkbox"/> 5 extreme
Assault/violent	<input type="checkbox"/> 1 none	<input type="checkbox"/> 2 low	<input type="checkbox"/> 3 moderate	<input type="checkbox"/> 4 high	<input type="checkbox"/> 5 extreme
Medications: Is the member prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Prescribing physician(s) name(s): _____			Is the member compliant with medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medications and dosages: _____		

Treatment plan and goals	
List primary complaint/problem to be addressed:	Overall progress toward goals: <input type="checkbox"/> 1 none <input type="checkbox"/> 2 minimal <input type="checkbox"/> 3 moderate <input type="checkbox"/> 4 met
List measurable treatment goals:	Compliance with treatment: <input type="checkbox"/> 1 none <input type="checkbox"/> 2 minimal <input type="checkbox"/> 3 moderate <input type="checkbox"/> 4 met

Treatment request
<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Family <input type="checkbox"/> Med management <input type="checkbox"/> ECT (call BH UM for PA)
Reason for authorization of non-participating providers (Utilization Management will contact provider directly before giving an authorization)

Participating provider
1. Specialty of provider to meet the needs of the member: _____
2. Continuity of care concerns: _____
3. Accessibility/availability of provider: _____
4. Clinical rationale: _____

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Total sessions requested: _____ Frequency of visits: _____ CPT codes: _____	Start date: _____ Estimated end date: _____
Provider signature: _____	Date: _____