

# PROVIDERALERT



**To:** AmeriHealth Caritas Louisiana Providers

**Date:** March 13, 2026

**Subject:** Assertive Community Treatment (ACT) Outpatient Treatment Request (OTR) Form

**Summary:** Office of Behavioral Health (OBH) approved Assertive Community Treatment (ACT) Outpatient Treatment Request (OTR) form.

AmeriHealth Caritas Louisiana would like to inform you that the OBH approved Assertive Community Treatment (ACT) Outpatient Treatment Request (OTR) form is now available on our [website](#) and can be faxed to AmeriHealth Caritas Louisiana Behavioral Health at 1-855-301-5356. This form will be used across all Healthy Louisiana plans when requesting ACT services.

**Questions:** Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your [Provider Network Management Account Executive](#).

**Missed an alert?** You can find a complete list of provider alerts on our website's [Provider Newsletters and Updates](#) page.

**Need to update your provider information?** Send full details to [network@amerihealthcaritasla.com](mailto:network@amerihealthcaritasla.com).

# Assertive Community Treatment (ACT) Outpatient Treatment Request (OTR) Form



Date:	Member name:
<input type="checkbox"/> Initial request	# Units requested:
<input type="checkbox"/> Continued stay/Requesting additional units	CPT: H0039
Last authorization #:	Modifiers:
Date member initially start receiving services:	Authorization start date:
Units will be authorized at one unit per month.	Authorization end date:

Member DOB:	Medicaid/Health plan #:
Legal guardian if not self:	Member phone#:
Member address:	
City, state:	ZIP:

Requesting provider:	Servicing provider: <input type="checkbox"/> same as requesting
NPI#:	NPI#:
TIN#:	TIN#:
LMHP/MD name:	LMHP/MD name:
Contact name:	Contact name:
Contact phone:	Contact phone:
Contact fax:	Contact fax:
Contact email:	Contact email:

DSM diagnosis code:
ICD-10 code:
Level of functional impairment: <input type="checkbox"/> No impairment <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Risk of harm to self or others: <input type="checkbox"/> No risk <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Progress towards goals: <input type="checkbox"/> N/A (initial request) <input type="checkbox"/> Making progress towards goals <input type="checkbox"/> Lack of adherence and/or progress



**PLEASE SUBMIT THIS FORM WITH THE FOLLOWING ITEMS:**

<b>For initial authorization</b>	
<input type="checkbox"/>	An initial assessment that includes psychiatric history, mental status exam, diagnosis, and information needed to determine medical necessity and, if the member meets eligibility criteria, to receive ACT services
<input type="checkbox"/>	LOCUS scoresheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date
<input type="checkbox"/>	Initial treatment plan (including goals with focus of treatment and transition/discharge plan) with signatures of member, team leader, and prescriber
<input type="checkbox"/>	Member choice/Freedom of choice form

<b>For continuing stay authorization:</b>	
<input type="checkbox"/>	<p>Comprehensive person-centered needs assessment updated every six months</p> <ul style="list-style-type: none"> <li>• The sections of the person-centered needs assessment shall be completed by ACT team members with subject matter expertise as indicated by their role within the program.</li> <li>• The entire assessment shall be reviewed and signed off on by the LMHP.</li> </ul>
<input type="checkbox"/>	LOCUS scoresheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date.
<input type="checkbox"/>	Treatment plan (including goals with focus of treatment and transition/discharge plan) updated every three months with signatures of member, team leader, and prescriber.
<input type="checkbox"/>	ACT Transition Assessment Scale updated every six months
<input type="checkbox"/>	Career profile/Vocational assessment updated every six months
<input type="checkbox"/>	<p>Progress summary completed within the past 30 days of the continuing stay authorization request. A progress summary shall include the following:</p> <ul style="list-style-type: none"> <li>• Document the time period summarized.</li> <li>• Indicate who was contacted, where contact occurred and what activity occurred.</li> <li>• Record activities and actions taken, by whom, and progress made.</li> <li>• Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable.</li> <li>• Document delivery of each service identified on the treatment plan, as applicable.</li> <li>• Document any deviation from the treatment plan.</li> <li>• Record any changes in the member’s medical condition, behavior, or home situation that may indicate a need for a reassessment and treatment plan change, as applicable.</li> <li>• Be legible (including signature) and include the functional title of the person making the entry and date.</li> </ul>



By my signature below, I hereby attest that all of the information above is true and accurate to the best of my knowledge.

Printed LMHP/Provider name and credentials:

Signature of provider/clinician:

Submitted by:

Date: