AmeriHealth Caritas Louisiana

www.amerihealthcaritasla.com

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:	❑ PAR ❑ NON PAR ❑ In credentialing process	
Group/agency name:	Provider credential: ❑ MD ❑ PhD ❑ LMHP ❑ LAC ❑ NP ❑ 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: ❑ None ❑ By history or ❑ Current/active	Tobacco abuse: ❑ None ❑ By history or ❑ Current/active	Gaming abuse: ❑ None ❑ By history or ❑ Current/active

Substance(s) used, amount, frequency and last used: _____

Previous or current waiver services: ❑ Yes ❑ 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? ❑ Yes ❑ No ❑ 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	❑ 1 none	❑ 2 low	❑ 3 moderate	❑ 4 high	❑ 5 extreme
Homicidal	❑ 1 none	❑ 2 low	❑ 3 moderate	❑ 4 high	❑ 5 extreme
Assault/violent	❑ 1 none	❑ 2 low	❑ 3 moderate	❑ 4 high	❑ 5 extreme

Medications: Is the member prescribed medications?	**Is the member compliant with medications?**
❑ Yes ❑ No Prescribing physician(s) name(s):	❑ Yes ❑ No Please list medications and dosages:

Treatment plan and goals	
List primary complaint/problem to be addressed:	Overall progress toward goals: ❑ 1 none ❑ 2 minimal ❑ 3 moderate ❑ 4 met
List measurable treatment goals:	Compliance with treatment: ❑ 1 none ❑ 2 minimal ❑ 3 moderate ❑ 4 met

Treatment request

❑ Individual ❑ Group ❑ Family ❑ Med management ❑ 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: _____

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