illinicare health

SUBMIT TO
Utilization Management Department
PHONE 866-329-4701 | FAX 844-528-3453

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID #_____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary_____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with family? ☐ Yes ☐ No

Time of call by provider/agency_____

Time of assessment by provider/agency_____

IP Appropriate Hospital ☐ 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 (5)	☐ No (0)
4. In the last 30 days, has alcohol or drug use caused problems for you?	☐ Yes (0)	☐ No (5)
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 out the home? ☐ Yes (5) ☐ No (0)		
8. Do you feel optimistic about the future?	☐ Yes (0)	☐ No (5)
Children Only:		
9. Are you currenlty employed or attending school?	☐ Yes (0)	☐ No (5)
10. In the last 30 days, have you been at risk of loosing your living situation?	☐ Yes (0)	☐ No (5)
Adults Only:		
11. Are you currenlty employed or attending school?	☐ Yes (0)	☐ No (5)
12. In the last 30 days, have you been at risk of loosing 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 Discharge

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

	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐
Decreased Energy	☐	☐	☐
Delusions	☐	☐	☐
Depressed Mood	☐	☐	☐
Hallucinations	☐	☐	☐
Angry Outbursts	☐	☐	☐

	Mild	Moderate	Severe
Hyperactivity/Inattn.	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐
Impulsivity	☐	☐	☐
Hopelessness	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐

Other (include severity): _____

Member Name

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

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐

Last Date of Substance Use:_____

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐

Drug(s) of Choice:_____

RISK ASSESSMENT

Suicidal: ☐ None ☐ Ideation Date of last episode _____ ☐ Planned ☐ Imminent Intent ☐ History of self-harming behavior

Homicidal: ☐ None ☐ Ideation Date of last episode _____ ☐ Planned ☐ Imminent Intent ☐ History of harm to others

Safety Plan in place? (If plan or intent indicated): ☐ Yes ☐ No

If prescribed medication, is member compliant? ☐ Yes ☐ No

CURRENT MEASURABLE TREATMENT GOALS

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

	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Requested end date for this auth (Not to exceed 6 months)
BH OP SERVICES (BILLED WITH CPT CODES)				
☐ Individual Therapy (90832, 90834, 90837)				
☐ Group Therapy (90853)				
☐ Family Therapy (90847, 90849)				
CMHC ONLY				
☐ Case Management T1016 (15 min units) ☐ Check here if member has exhausted the allowed 200 lifetime units				
☐ Individual/Group/Family Therapy H0004 (15 min units)				
☐ Assertive Community Treatment H0039 (15 min units)				
☐ Crisis Intervention H2011 (15 min units) Must notify within 48 hours of each encounter.				
☐ Community Support H2015 (15 min units)				
☐ Psychosocial Rehabilitation H2017 (15 min units) ☐ Check here if member has exhausted the allowed 800 lifetime units				

IF YOU ARE A NONPARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR. OTHER CODES (REQUESTED):

☐				
☐				
☐				
☐				

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Additional Information?

Clinician Signature Date

Clinician Signature Date

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PLEASE ATTACH IM – CAT