SUBMIT TO
**Utilization Management Department**
PHONE 1-866-595-8133 | FAX 1-888-725-0101

louisiana healthcare connections™

# OUTPATIENT TREATMENT REQUEST FORM-NON PARTICIPATING PROVIDERS

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

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 PCP? ☐ Yes ☐ No

Date first seen by provider/agency_____

Date last seen by provider/agency_____

## 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/your child 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 or your child? | ☐ Yes (0) | ☐ No (5) |
| 5. In the last 30 days, have you/your child gotten in trouble with the law? | ☐ Yes (5) | ☐ No (0) |
| 6. In the last 30 days, have you/your child 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/your child 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. In the last 30 days, has your child had trouble following the rules at home or school? | ☐ Yes (0) | ☐ No (5) |
| 10. In the last 30 days, has your child been placed in state custody (DCFS or Juvenile Justice)? | ☐ Yes (5) | ☐ No (0) |
| **Adults Only** | | |
| 11. Are you currently employed or attending school? | ☐ Yes (5) | ☐ No (0) |
| 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 Discharge

## 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): | ☐ | ☐ | ☐ | ☐ |

## FUNCTIONAL IMPAIRMENT (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:_____

_____Member Name

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

## CURRENT MEASURABLE TREATMENT GOALS

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

| PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING. | DATE SERVICE: STARTED | FREQUENCY: How Often Seen | INTENSITY: # Units Per Visit | Requested Start Date for this Auth | Anticipated Completion Date of Service |
|---|---|---|---|---|---|
| **ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING** | | | | | |
| Psychiatric/Psychological Services<br>☐ 900<br>☐ 914<br>☐ 915<br>☐ 916 | | | | | |
| Psychiatric diagnosis evaluation<br>☐ 90791<br>☐ 90792 | | | | | |
| ☐ 90832 Psychotherapy, 30 minutes<br>☐ 90834 Psychotherapy, 45 minutes<br>☐ 90837 Psychotherapy, 60 minutes | | | | | |
| ☐ 90845 Individual psychotherapy | | | | | |
| Family psychotherapy<br>☐ 90846<br>☐ 90847<br>☐ 90849<br>☐ 90853 | | | | | |
| Pharmacological management<br>☐ 90863 | | | | | |
| Individual psycho-physiological therapy<br>☐ 90875<br>☐ 90876<br>☐ 90880 | | | | | |
| Health and behavior assessment<br>☐ 96150<br>☐ 96151 | | | | | |
| Health and behavior intervention<br>☐ 96152<br>☐ 96153<br>☐ 96154<br>☐ 96155 | | | | | |
| Psychotherapy with Med Eval/Mgmt Service; Limited to 1 per day per provider<br>☐ 99201<br>☐ 99202<br>☐ 99203<br>☐ 99204<br>☐ 99205 | | | | | |
| Office or other outpatient visit<br>☐ 99211<br>☐ 99212<br>☐ 99213<br>☐ 99214<br>☐ 99215 | | | | | |
| Alcohol and/or Drug Assessment; 1 per day<br>☐ H0001 HO/HN/HM | | | | | |
| Behavioral health counseling and therapy - per 15 minutes<br>☐ H0004 HO/HN/HM | | | | | |
| Alcohol and/or drug services; per hour<br>☐ H0005 HO/HN/HM<br>☐ H0011<br>☐ H0012<br>☐ H0014 | | | | | |
| community psychiatric supportive treatment<br>☐ H0036 HO/HN/HM<br>☐ H0036 HO/HN- Homebuilders<br>☐ H0036 HE- FFT (Functional Family Therapy) | | | | | |

Member Name _____

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|---|---|---|---|---|---|
| Respite Care-Does not require Authorization for up to 7 days. After 7 days Authorization is required.<br>☐ H0045 HA<br>☐ S9125 | | | | | |
| Multi systemic therapy<br>☐ H2033 HO | | | | | |
| Psychiatric health facility service, per diem<br>☐ H2013 | | | | | |
| Psychosocial Rehabilitative Services<br>☐ H2017 individual office<br>☐ H2017 HA/HQ child/adolescent program, office group<br>☐ H2017 HA/HQ child/adolescent program, group place of service 11 or 53 for home and community<br>☐ H2017 HB/HQ adult program, non-geriatric, office group<br>☐ H2017 HB/HQ adult program, non-geriatric, group place of service 11 or 53 for home and community<br>☐ H2017 TG (PSR)<br>☐ H2017 TG/U8 (PSR) | | | | | |
| Foster Care, Therapeutic, Child; Per Diem<br>☐ S5145 | | | | | |

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 printed name _____ Date _____

Clinician Signature _____ Date _____

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**Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).**