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

louisiana healthcare connections™

OUTPATIENT TREATMENT REQUEST FORM

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 (0) ☐ No (5)
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
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Hyperactivity/Inattn.	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐
Other (include severity):	☐	☐	☐	☐

FUNCTIONAL IMPAIRMENT (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	☐ 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: # OF UNITS PER VISIT	REQUESTED START DATE FOR AUTH	ANITCIPATED COMPLETION: DATE OF SERVICE
ALL OUT OF NETWORK SERVICES REQUIRE PRIOR AUTHORIZATION. PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING					
Behavioral Health Outpatient Services (billed with CPT Codes) ☐ Individual Therapy ☐ Group Therapy ☐ Family Therapy					
Alcohol and/or Drug Services ☐ H0011 ☐ H0012 ☐ H0014					
Respite Care (No authorization requirement for 7 days After 7 days, authorization is required) ☐ H0045 HA ☐ S9125					
Community Psychiatric Suport Treament ☐ H0036 HO/HN/HM ☐ H0036 HO/HN (Homebuilders) ☐ H0036 HE Functional Family Therapy (FFT)					
Assertive Community Treatment Program (ACT) ☐ H0039					
Psychiatric Health Facility Service, per diem ☐ H2013					
Psychosocial Rehabilitative Services ☐ H2017 Individual Office ☐ H2017 HA/HQ child/adolescent program,office group ☐ H2017 HA/HQ child/adolescent program, group place of service. 11 or 53 for home and community ☐ H2017 HB/HQ adult program, non-geriatric, office group ☐ H2017 HB/HQ adult program, non-geriatric group place of service. 11 or 53 for home and community. ☐ H2017 TG (PSR) ☐ H2017 TG/U8 (PSR)					
Foster Care, Therapeutic, Child, per diem ☐ S5145					

PRIOR AUTHORIZATION FOR PSYCHOTHERAPY CODES (EXCESS OF 12 SESSIONS IN A CALENDAR YEAR BY A SINGLE PROVIDER)

PLEASE INDICATE BELOW WHICH CODES YOU ARE REQUESTING	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	AUTH BY SERVICES: # OF VISITS	REQUESTED START DATE FOR AUTH	ANITCIPATED COMPLETION: DATE OF SERVICE
☐ 90832 Psychotherapy 30 min. with parient and.or family member					
☐ 90833* Pschotherapy 30 min. with patient with patient and/or family member when performed with an E/M service					
☐ 90834 Psychotherapy 45 min. with patient and/or family member					
☐ 90836* Psychotherapy 45 min. with patient and/or family member when performed with an E/M service					
☐ 90837 Psychotherapy 60 min. with patient and/or family member					
☐ 90838* Psychotherapy 60 min. with patient and/or family member when performed with an E/M service					
☐ 90840 Psychotherapy for Crisis each additional 30 min.					
☐ 90847 Family Psychotherapy conjoint psychotherapy; with patient present					
☐ 90849 Multiple Family Group Psychotherapy					
☐ 90853 Group Psychotherapy other than of a multiple family group					
☐ 90845 Psychoanalysis					
☐ 90875 Individual Therapy with Biofeedback 30 min.					
☐ 90876 Individual Therapy with Biofeedback 60 min					

* If this add-on code is billed with any other service, that visit will count towards the 12 visits.

Are you requesting beyond the recommended guidelines of the HCBS? If so, please provide a brief justification or rationale for the increase in requested units.

If this is a re-authorization, please provide a brief narrative expressing the success or lack of success during the previous authorization period. Describe what worked for the member, what did not work for the member, and what will be different moving forward.

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.).