Outpatient Treatment Request

MENTAL HEALTH REHABILITATION (CPST & PSR)

Please print clearly—incomplete or illegible forms may delay processing.

Instructions

Submit these documents:	**By fax to:**
□ This Outpatient Treatment Request form □ LOCUS/CALOCUS Assessment (completed within last 180 days) □ Treatment Plan □ Healthy Louisiana Behavioral Health Assessment (adults only, annually) □ Homebuilders approval (if applicable) □ Additional supporting documentation (if applicable)	**1-888-725-0101**

This form is for the initial request for CPST or PSR, and each six-monthly request thereafter. Renewal every 60 days may be requested using the Renewal OTR.

Provider Information

Clinician: PLEASE PRINT _____ Credentials: _____

Phone: _____ Secure Fax: _____

Agency NPI: _____ Agency TIN: _____

Address: _____

City: _____ State: _____ Zip: _____

Member Information

First Name: PLEASE PRINT _____ Last Name: PLEASE PRINT _____

Medicaid ID: _____ Birth Date: MM/DD/YYYY _____

Primary Diagnosis ICD-10 Code: _____

Co-morbid Medical Diagnosis ICD-10 Code: _____

Discharge & Treatment Planning

Have you discussed the discharge plan from the requested services with the member? □ Yes □ No

Target discharge date from the requested services (MM/DD/YYYY): □ N/A

If "**No**" or "**N/A**" above, please explain:

Has the member (or guardian) signed the Treatment Plan and agreed to participate? □ Yes □ No

Assessment and Evaluation

Date of the most recent Developmental/Comprehensive Evaluation/Functional Behavioral Assessment: _____

Tip: The assessment's findings should be reflected in the treatment plan.

LOCUS/CALOCUS and Treatment Plan

LOCUS/CALOCUS DOMAIN	RATING	TREATMENT PLAN GOAL ASSOCIATED WITH ASSESSMENT FINDINGS
Risk of Harm SI/HI/Command AH, risky behaviors, impulsivity		
Impairment in Functional Status Self-care, fulfilling daily life roles, socialization and interpersonal deficits which is a change from baseline		
Presence of Co-Morbidity Co-occurring physical health or substance abuse conditions		
Environmental Factors Degree of life stressors with ability to cope effectively and degree of support or lack thereof		
Engagement and Recovery Status Member's level of change and acceptance / responsibility of condition(s)		

Member Risk

	None	Mild Ideations only	Moderate Ideations with EITHER plan or history of attempts	Severe Ideations AND plan, with either intent or means	Not Assessed
To Self:	□	□	□	□	□
To Others:	□	□	□	□	□

Crisis Management / Safety Plan

Does the member have a behavioral health crisis management or safety plan in place? □ Yes □ No □ Unknown

If yes, what is the date of the most recent plan? (MM/DD/YYYY):

Requested Authorization

CODES / MODIFIERS REQUESTED	SERVICE DATES MM/DD/YYYY	Frequency: HOW OFTEN SEEN	Intensity: # OF UNITS PER VISIT	TOTAL UNITS REQUESTED
Community Psychiatric Support Treatment □ H0036 HO/HN/HM □ H0036 TG/U8 (PSR) – Permanent Supportive Housing	Request Start: Request End: *(Standard: 60 days)*			
Psychosocial Rehabilitative Services H2017 Individual Office or Community □ H2017 HA/HQ child/adolescent program □ H2017 HB/HQ adult program, non-geriatric □ H2017 TG (PSR) □ H2017 TG/U8 (PSR) – Permanent Supportive Housing	Request Start: Request End: *(Standard: 60 days)*			

Tip: Be sure to indicate the appropriate place of service code when you submit your claim.

Service Coordination

Have traditional behavioral health services been attempted (e.g., individual/family/group psychotherapy, medication management, etc.)? If so, how are these services alone inadequate in treating the diagnosis? □ Yes □ No

If additional services are being requested for Homebuilders, has the Homebuilder's consultant approved the requested services? If yes, attach approval. □ Yes □ No □ N/A

Member receives mental health services in the following locations *(check all that apply)*:

□ Outpatient clinic
□ School site (attach IEP, if applicable, once per school year)
□ Community clubhouse
□ General community
□ Member's home

Additional Information (Optional)

This space is for any additional information you believe to be relevant. Additional pages may be attached if needed.

Attestation of Licensed Clinician

It is important to the health outcomes of our members that licensed providers are actively engaged in the mental health rehabilitation services delivered under their supervision. The Louisiana Department of Health Behavioral Health Provider Manual also emphasizes the importance of active supervision by a licensed provider:

> *"The medical necessity for these rehabilitative services must be determined by and services recommended by a licensed mental health professional or physician, or under the direction of a licensed practitioner, to promote the maximum reduction of symptoms and restoration to his/her best age appropriate functional level."*

By signing below, I, a licensed mental health clinician, attest that:

The LOCUS/CALOCUS assessment was completed by myself (or another licensed mental health clinician at my agency) face-to-face directly with the member, or in the case of a pre-verbal minor, face-to-face directly with the member's legal guardian.

The Treatment Plan was developed by myself (or another licensed mental health clinician at my agency), and the member has been determined to have the ability to participate in and benefit from this Treatment Plan.

I have determined the requested services are medically necessary and the contents of this Outpatient Treatment Request are true and accurate.

Clinician: PLEASE PRINT _____ Signature: _____

License #: _____ Date: _____

NPI: _____