Outpatient Treatment Request for Renewal

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 for Renewal form Optional, if applicable: ☐ Treatment Plan (only if modified) ☐ Homebuilders approval (only if applicable) ☐ Additional supporting documentation (only if applicable)	**1-888-725-0101**

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 Planning

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

Target discharge date from the current level of services (MM/DD/YYYY): ☐ N/A

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

Member Attendance and Engagement

Since the last outpatient treatment request, did the member attend and engage in the requested services?

☐ Fully (100%) ☐ Partially (70% - 99%) ☐ Poorly (50% - 69%) ☐ Did not (0% - 50%)

If member did not fully participate, why not?

☐ Member had inpatient hospitalization ☐ Member was incarcerated ☐ Member non-compliant with treatment plan ☐ Other (explain below):

Progress toward Measurable Treatment Goals

Use the "Additional Information" section on the last page to describe any barriers to reaching goals and the treatment response to address those barriers.

Treatment Goal 1:							
Progress since last review:	☐ 0 – 5% Goal Attainment	☐ 5 - 19% Goal Attainment	☐ 20 – 39% Goal Attainment	☐ 40 – 59% Goal Attainment	☐ 60 – 79% Goal Attainment	☐ 80 – 99% Goal Attainment	☐ 100% Goal Attainment
Treatment Goal 2:							
Progress since last review:	☐ 0 – 5% Goal Attainment	☐ 5 - 19% Goal Attainment	☐ 20 – 39% Goal Attainment	☐ 40 – 59% Goal Attainment	☐ 60 – 79% Goal Attainment	☐ 80 – 99% Goal Attainment	☐ 100% Goal Attainment
Treatment Goal 3:							
Progress since last review:	☐ 0 – 5% Goal Attainment	☐ 5 - 19% Goal Attainment	☐ 20 – 39% Goal Attainment	☐ 40 – 59% Goal Attainment	☐ 60 – 79% Goal Attainment	☐ 80 – 99% Goal Attainment	☐ 100% Goal Attainment

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:	☐	☐	☐	☐	☐

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.)? □ 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

What is the current frequency of psychiatric visits? □ Weekly □ Every other week □ Monthly □ Other:

Have there been any changes to psychotropic medications since the last request? □ Yes □ No □ Unknown

Has the member participated in medication management since the last request? □ Yes □ No □ Unknown

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:

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

Clinician: PLEASE PRINT _____ Signature: _____

License #: _____ Date: _____

NPI: _____