Healthy Blue

Medicaid Managed Care

Behavioral Health Outpatient Treatment Request Form

Submit completed form using our preferred method online at **https://providers.healthybluela.com** or by fax to **1-844-432-6028**. Please fill out completely to avoid delays.

Date:		**Type of request:**	☐ Initial request ☐ Continued stay request
Identifying data			
Patient's name:			
Medicaid ID:			Date of birth:
Patient's address:			
City and state:			ZIP code:
Provider information			
Provider name:		NPI:	
Tax ID:	Phone:		Fax:
PCP name:			PCP NPI:
Name of other behavioral health providers:			
1.		2.	
3.		4.	
DSM-5/ICD-10 diagnoses			
Medications	☐ Check if member is not adherent to medication regimen. ☐ Check if member is not taking any medications.		
Current medications (indicate changes since last report):		Dosage:	Frequency:

Current risk factors	
Suicide:	☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm self
Homicide:	☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm others
Physical or sexual abuse or child/elder neglect:	☐ Yes ☐ No • If Yes, patient is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither (but abuse exists in family) • Abuse or neglect involves a child or elder: ☐ Yes ☐ No • Abuse has been legally reported: ☐ Yes ☐ No
Symptoms that are the focus of current treatment *(may include specific testing to support and correlate with DSM diagnoses, observations of behavior or chief complaints)*:	

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Progress since last review (*including what is being re-evaluated or changed, whether member is being reassessed, medication changes, any stressors or supports that may contribute or serve as a barrier*):
Functional impairments or strengths (*including interpersonal relations, personal hygiene, work/school*) — Identify specific behaviors:
Describe recovery environment (*including support system, level of stress*):

Engagement/level of active participation in treatment:
Housing:
Co-occurring medical/physical illness:
Family history of mental illness or substance abuse:

Trauma-informed care — Individuals have experienced potentially traumatic events in their lifetime. It is imperative everyone is aware of the potential impact of trauma on those they serve, mindful of how their policies and procedures may affect those who use their services, and prepared to recognize and offer trauma-specific services when needed.
Is there evidence to suggest this member has experienced trauma? Yes ☐ No ☐
What is your plan to assess and address the current and potential effects of that trauma?

Patient's treatment history including all levels of care:

Level of care	Number of distinct episodes/ sessions	Date of last episode/ session	Level of care	Number of distinct episodes/ sessions	Date of last episode/ session
Outpatient psych			Inpatient psych		
Outpatient — substance abuse			Inpatient — substance abuse		
Residential treatment center (RTC) — substance abuse			RTC — psych		

Requested service authorization:

Procedure code (for example, H2017):	Number of units (for example, 240):	Frequency (for example, 3 times a week):	Requested start date (for example, 3/1/17):	Requested end date (for example, 3/1/17):

Treatment goals for each type of service (specify) with expected dates to achieve them (*should correlate with symptoms and DSM diagnoses*):
1.
2.
3.
4.
5.

MEASURED objective outcome criteria by which goal achievement is determined:
1.
2.
3.
4.
5.

Discharge plan and estimated discharge date:

Expected outcome and prognosis:

☐ Return to normal functioning
☐ Expect improvement, anticipate less than normal functioning
☐ Relieve acute symptoms, return to baseline functioning
☐ Maintain current status, prevent deterioration

Please note: Psychological/neuropsychological testing requests require a separate form.

Treatment plan coordination:
I have requested permission from the member/member's parent or legal guardian* to release information to the PCP. ☐ Yes ☐ No — If no, rationale why this is inappropriate: _____ _____ _____ _____ _____ _____
Treatment plan was discussed with and agreed upon by the member/member's parent or legal guardian:* ☐ Yes ☐ No
* Include the **name of legal guardian** (if applicable) and any agencies involved with the member (for example, Department of Child & Family Services, Office for Citizens with Developmental Disabilities, etc.):

Please attach summary sheets of ASAM, LOCUS, CASII, CALOCUS or other applicable assessments.

Provider's signature: _____

Date: _____

Disclaimer: Authorization indicates that Healthy Blue determined medical necessity has been met for the requested service(s) but does not guarantee payment. Payment is contingent upon the eligibility and benefit limitations at the time services are rendered.

Tips:

- Healthy Blue accepts additional supporting clinical documentation relevant to authorization requests, such as the *Freedom of Choice* form, any service plans developed for member (OAD, OCDD, DCFS plans) or latest assessments.
- When submitting for continued stay, it helps to document severity of illness; specific symptoms of diagnoses; symptoms that treatment is targeting; and how provider plans to address each issue, engagement/motivation or lack of support, functional impairment, etc.