SUBMIT TO
Utilization Management Department
Phone: 1.888.282.7767 FAX 1.866.694.3649

nh healthy families

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-10 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/your child had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you/your child 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 (5) ☐ No (0)
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/your child 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 (5) ☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)? ☐ Yes (5) ☐ No (0)

Adults Only

11. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
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 RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐

Last Date of substance use:_____

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐

Drug(s) of Choice:_____

_____Member Name

RISK ASSESSMENT

Suicidal:	☐None	☐Ideation	☐Planned	☐Imminent Intent	☐History of self-harming behavior
Homicidal:	☐None	☐Ideation	☐Planned	☐Imminent Intent	☐History of self-harming behavior
Safety Plan in place? (If plan or intent indicated):			☐Yes	☐No	
If prescribed medication, is member compliant?			☐ Yes	☐ No	

CURRENT MEASURABLE TREATMENT GOALS (PLEASE ENSURE THAT GOALS ARE S.M.A.R.T: "SPECIFIC, MEASURABLE, ACHIEVABLE, REALISTIC, AND TIME- BOUND)

REQUESTED AUTHORIZATION

Services Requested: ☐ Individual ☐ Group ☐ Family ☐ Med Management ☐ ECT (Call Medical Management)

Total sessions requested:_____ Frequency of visits:_____ CPT Codes:_____

Estimated # of sessions to complete treatment episode:_____ Requested Start Date:_____

Please specify additional behavioral health services desired if not listed above; include CPT code, intensity, start date, and end date below:

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 Signature

Date of Signature (Not to exceed 30 days)

Please include additional information to support your request (e.g assessment, progress notes, updated treatment plan with SMART goals)

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