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 (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

Behavioral Health Outpatient Servies	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Requested End Date for this Auth
☐ T1001 Nursing Assessment				
☐ 90801/90802 Psychiatric Diagnostic Interview (if more than one in a rolling 6 months)				
☐ Individual Psychotherapy				
☐ Family Psychotherapy				
☐ Group Psychotherapy				
☐ H0035 Mental Health Partial Hospitalization (less than 24 hrs)				
☐ H0046 Mental Health Services not otherwise Specified				
☐ H2015 Comprehensive Community Support Services				
☐ H2019 Therapeutic Behavioral Services				
☐ H2019 Therapeutic Behavioral Services--Group				
☐ H2020 Therapeutic Behavioral Service-- Per Diem				
☐ H2023 Supported Employment Services				
☐ H2027 Psycho-Education (IMR)				
☐ H2027 Psycho-Education-Group (IMR)				
☐ T1016 Case Management				
☐ T1027 Family Training and Counseling (IRO/FSS)				

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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