HHW / HIP OUTPATIENT TREATMENT REQUEST (OTR)
Please print clearly – incomplete or illegible forms will delay processing

MHS – facsimile # 1.866.694.3649

MEMBER INFORMATION

Patient Name _____

Health Plan _____

DOB _____

Medicaid RID # _____

Last Authorization # _____

PROVIDER INFORMATION

Provider Name _____

Provider Credential MD ☐ PHD ☐ OTHER ☐

Group / Agency Name _____

Physical Address _____

Telephone Number _____ Facsimile Number _____

Medicaid / TPI / NPI # _____ Tax ID # _____

Please indicate to whom the authorization should be made Individual Provider (Y/N)_____ Group / Facility (Y/N)_____

PREVIOUS BH/SA TREATMENT ☐ None or ☐ OP ☐ MH ☐ SA and/or ☐ IP ☐ MH ☐ SA

List names / dates including hospitalizations if applicable: _____

Substance Use: ☐ None ☐ By History and/or ☐ Current/Active **Tobacco Abuse**: ☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency & last used: _____

Current ICD Diagnosis:

Primary_____

Secondary _____

Tertiary _____

Additional _____

Additional _____

If the Member has a substance use and / or HIV diagnosis, has a consent to release information for these related conditions been obtained?
☐ Yes ☐ No ☐ N/A

Primary Medical Physician (PMP) Communication

Has information been shared with the PMP regarding:

- The initial evaluation & treatment plan? ☐ Yes ☐ No
- This updated evaluation & treatment plan ☐ Yes ☐ No

PMP Name/Date last notified:

_____

If No, explain:

_____

Current Risk/Lethality

Suicidal	☐ 1 NONE	☐ **2 LOW***	☐ **3 MOD***	☐ **4 HIGH***	☐ **5 EXTREME***
Homicidal	☐ 1 NONE	☐ **2 LOW***	☐ **3 MOD***	☐ **4 HIGH***	☐ **5 EXTREME***
Assault/ Violent Behavior	☐ 1 NONE	☐ **2 LOW***	☐ **3 MOD***	☐ **4 HIGH***	☐ **5 EXTREME***

Current Risk/Lethality *2-5, Progress/Compliance *1-2 checked, give intervention: _____

Please answer YES or NO to the following questions:

Is Member currently participating in any community based support groups / interventions? _____

Are the Member's family/supports involved in treatment? _____

Coordination of care with other behavioral health providers? _____

Coordination of care with medical providers? _____

Has Member been evaluated by a Psychiatrist? _____

Is this Member currently receiving Medicaid Rehabilitation Option Services? (If yes, please describe)

Treatment Goals

List primary complaint / problem to be addressed:

List measureable treatment goals:

Discharge Goals

Objectively describe how you will know the patient is ready to discontinue treatment:

_____

*Overall **Progress** toward goal:

	☐ **1 NONE***	☐ **2 MIN***	☐ 3 MOD	☐ 4 MAX	☐ 5 MET

***Compliance** with treatment:

	☐ **1 NONE***	☐ **2 MIN***	☐ 3 MOD	☐ 4 MAX	☐ 5 MET

Medical Psychiatric Eval done? (even if PMP providing meds) ☐ Yes ☐ No

Medication given by ☐ Psychiatrist ☐ PMP ☐ N/A

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:** _____

Provider Signature/ Date: _____