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

MHS PHONE 1.877.647.4848
FAX 1.866.694.3649

mhs

MEMBER INFORMATION

Patient Name ______________________

Health Plan ______________________

DOB ______________________

Medicaid ID # ______________________

Last Authorization # ______________________

PROVIDER INFORMATION

Provider Name ______________________

Provider Credential MD ☐ PHD ☐ OTHER ☐

Group / Agency Name ______________________

Physical Address ______________________

Telephone Number ______________ FAX 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: ______________________

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