



BEHAVIORAL HEALTH TREATMENT PLAN REQUEST FORM
Confidential Information – Fax completed form with cover sheet to 1 (888) 496-1540

Patient Name: _____ Patient ID: _____ DOB: _____
Provider Name: _____ Provider NPI: _____
Provider Phone #: _____ Provider Fax #: _____
Physical/Service Address: _____
Requested Start Date of Authorization: _____

I. Diagnosis: Use DSM-IV; Include all Axes
Axis I _____ Functional Impairments: Job/School Relationships/Family
Axis II (Personality) _____ Disability Other _____
Axis III (Medical conditions) _____
Axis IV (Stressors) _____
Axis V (GAF) Current _____ Highest in the last 12 months _____

II. Current Risk Factors: Check all that apply and explain in Presenting Symptoms section
Suicidal/Homicidal Ideation: (None) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 (Severe) Safety Plan
Substance Abuse: None Remission Unstable Remission Abuse Under Evaluation

III. Treatment Information – Current Episode
First Date of Service: _____ Number of Sessions to date: _____
Number of Sessions Requested at this time: _____
Frequency to date: _____ Frequency Requested: _____
Modality to date: 90806 # ___ 90807 # ___ 90846 # ___ 90847 # ___ 90853 # ___ 90862 # ___
Modality requested: 90806 # ___ 90807 # ___ 90846 # ___ 90847 # ___ 90853 # ___ 90862 # ___
Type of plan: Short term focused Long term care Chronic care
Orientation: Cognitive/behavioral Psychodynamic Supportive/problem Solving Other _____
Identify referrals made (adjunctive therapy, community resources): _____
Have you coordinated care with PCP? Yes No With other providers? Yes No

IV. Medications, prescribed by: PCP PMHNP/ARNP Psychiatrist
Previous (dosage & length of time on medication) _____
Current (dosage & length of time on medication) _____

Reason for Treatment/Presenting Symptoms (specify functional impairments):

Relevant History (personal resources, mental health treatment history, relevant new information):

Treatment Goals (behaviorally defined): _____ _____	Progress made toward each goal: _____ _____
---	---

Termination Criteria (observable, measurable, and related to symptoms):

Estimated Number of Sessions to Termination of Current Episode of Treatment: _____

Signature: _____ Licensure: _____ Date: _____

- Fax the completed treatment plan to 1 (888) 496-1540
- To verify benefits and eligibility, please call the number on the back of the member’s card
- For treatment plan and authorization questions only, please call 1 (800) 787-5757