

For timely processing of your request, please fill out all sections of this form completely

## REGENCE BEHAVIORAL HEALTH TREATMENT PLAN REQUEST FORM

Confidential Information

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F  
Marital Status:  Married  Single  Divorced Number of Dependents: \_\_\_\_\_ Employment Status: \_\_\_\_\_  
Provider Name: \_\_\_\_\_ Provider ID/Rider #: \_\_\_\_\_  
Provider Phone #: \_\_\_\_\_ Service Address: \_\_\_\_\_  
Health/Benefit Plan:  FEP  PEBB-OR  RBCBS-OR  RBS-WA  RBCBS-UT  RBS-ID Other: \_\_\_\_\_

**I. Diagnosis – Use DSM-IV, Include All Axes:**  
Axis I: \_\_\_\_\_  
Axis II (Personality): \_\_\_\_\_  
Axis III (Medical conditions): \_\_\_\_\_  
Axis IV (Stressors): \_\_\_\_\_  
Axis V (GAF) Current: \_\_\_\_\_ Highest in the last 12 months: \_\_\_\_\_

**II. Current Risk Factors:**  
Suicidal/Homicidal Ideation: (None) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 (Severe)  Safety plan in place  
Substance Abuse:  None  Remission  Unstable Remission  Abuse  Dependence  Under evaluation

**III. Treatment Information – Current Episode:**  
First date of service: \_\_\_\_\_ First date of service this year: \_\_\_\_\_  
# of sessions to date: 90801 \_\_\_\_\_ 90806 \_\_\_\_\_ 90847 \_\_\_\_\_ 90853 \_\_\_\_\_ 90862 \_\_\_\_\_ Other: \_\_\_\_\_  
# of sessions requested: 90801 \_\_\_\_\_ 90806 \_\_\_\_\_ 90847 \_\_\_\_\_ 90853 \_\_\_\_\_ 90862 \_\_\_\_\_ Other: \_\_\_\_\_  
Current frequency: \_\_\_\_\_ Frequency requested: \_\_\_\_\_  
# of sessions to termination of current episode of treatment (estimated): \_\_\_\_\_  
Treatment orientation:  Cognitive/behavioral  Family systems  Psychodynamic  Other \_\_\_\_\_  
Have you coordinated care with: PCP  Yes  No Other providers or medication prescribers  Yes  No

**IV. Medications:**  
Current (dosage and length of time on medication): \_\_\_\_\_  
Prescribed by:  PCP  PMHNP/ARNP  Psychiatrist

**Presenting Symptoms and Related History:**

Treatment Goals (behaviorally defined):	Progress Made Toward Each Goal:

**Termination Criteria (briefly describe termination criteria; observable, measurable and related to symptoms):**

Signature: \_\_\_\_\_ Licensure: \_\_\_\_\_ Date: \_\_\_\_\_

- Fax the completed treatment plan to Asuris Behavioral Health at 1 (800) 331-3505
- Or mail this request to:  
Asuris Behavioral Health  
PO Box 1271, Mailstop E9H  
Portland, OR 97207-9861
- For treatment plan authorization questions only, please call Behavioral Health Customer Service 1 (800) 780-7881