



For Office Use Only:

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CM Approval by: _____

Services Approved and Date of Expiration:

GEORGIA OUTPATIENT TREATMENT REQUEST (OTR)

Please print clearly – incomplete or illegible forms will delay processing.

<p>I. <u>Demographics</u></p> <p>Patient Name: _____</p> <p>Subscriber Name: _____</p> <p>Health Plan: _____</p> <p>DOB: _____</p> <p>SS#: _____</p> <p>Patient ID#: _____</p> <p>Last Auth. # _____</p>	<p>II. <u>Provider Information</u> (Please indicate by checking below, whether requested services should be authorized to the provider or agency.)</p> <p>____ Provider Name (print): _____</p> <p>Professional Credential: ____ MD ____ PhD ____ Other _____</p> <p>____ Group/Agency Name: _____</p> <p>Physical Address: _____ (street address, city, state, zip)</p> <p>Phone Number: _____</p> <p>FAX Number: _____</p> <p>Medicaid/TPI #: _____ Tax ID#: _____</p>																		
<p>III. <u>Diagnosis</u> (All axes must be completed using DSM multi-axial format; use disorder names and complete codes with modifiers where applicable.)</p> <p>AXIS I _____</p> <p>AXIS II _____</p> <p>AXIS III _____</p> <p>AXIS IV _____</p> <p>AXIS V _____</p>	<p>IV. <u>Risk Assessment (check all that apply)</u></p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:20%; text-align: center;">Suicidality</th> <th style="width:20%; text-align: center;">Homicidality</th> </tr> </thead> <tbody> <tr> <td>Not Present</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Ideation</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Plan</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Means</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Prior Attempt (give dates)</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		Suicidality	Homicidality	Not Present	_____	_____	Ideation	_____	_____	Plan	_____	_____	Means	_____	_____	Prior Attempt (give dates)	_____	_____
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Prior Attempt (give dates)	_____	_____																	
<p>V. <u>Medical Conditions</u></p> <p>____ Asthma ____ Diabetes ____ CHF ____ COPD ____ Other</p> <p>Has communication been established with PCP? _____</p> <p>If no, did member refuse communication with PCP? __ YES __ NO</p>	<p>VI. <u>Treatment History</u></p> <p>Inpatient or residential mental health treatment in past 12 months? ____ yes ____ no</p> <p>Date of most recent episode: _____</p> <p>Inpatient or residential substance abuse treatment in past 12 months? ____ yes ____ no</p> <p>Date of most recent episode: _____</p> <p>If this authorization request is for substance abuse treatment, please describe substance abuse treatment history (when, level of care, treatment completed or not, length of sobriety following treatment, etc.):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>																		
<p>VII. <u>Concurrent Services</u></p> <p>What other treatment or community services is the patient currently receiving?</p> <p>____ individual therapy ____ AA/NA</p> <p>____ family therapy ____ other (please specify below)</p> <p>____ group therapy</p> <p>_____</p> <p>____ EAP</p> <p>_____</p> <p>____ medication management</p> <p>_____</p>																			

VIII. Substance Use History

Substances Used	Frequency/Amt Used	Age at First Use	Date/Amt of Last Use

Does treatment focus primarily or equally on substance-related disorder? ___ yes ___ no

IX. Treatment Plan

Presenting Problem: (Why did the patient present for treatment at this time? Please briefly and specifically describe the current situation/symptoms.)
For Community Based Service requests please describe any risk of out of home placement. CBS requests cannot be processed without this information.

Treatment Goals / Progress:

Describe measurable goals and treatment objectives and note progress. Please be specific in the documentation of progress made.

Measurable Goal / Date Initiated	Current Progress / Date Completed

Discharge Criteria:

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

X. Medication

Has patient been evaluated for medication? ___ yes ___ no Current medication? ___ None ___ Psychotropic ___ Medical

Medication	Dose / frequency	Prescribed by	Is patient compliant with prescription?

XI. Requested Authorization

Modality	Frequency?	# of sessions?
Individual therapy (90804, 90806, 90808, 90810, 90812, 90814, 90816, 90818, 90821, 90823, 90826, 90828, 90845)		
Family therapy (90846, 90847, 90849)		
Group therapy (90853, 90857)		
CSB Services – See Page 3		

XII. CBS - Treatment Service Requested Authorization

Service	Code	Frequency	# of units	Service	Code	Frequency	# of units
Family/Group/Individual Therapy	H0004 - 15 min units			Medication Administration	H2010 - 15 min units		
Family/Group Skills Training	H0004 - 15 min units			Crisis Mgmt.	H2011 - 15 min units		
Ambulatory Detox	H0014 - 15 min units			Community Support	H2015 - 15 min units		
BH Crisis Residential Services	H0018 - day units			Intensive Family Intervention	H2021 - 15 min units		
Methadone Admin and/or Services	H0020 - 15 min units			Activities Therapy	H2032 - 15 min units		
PHP	H0035 - 1 hr. units			Nursing Assessment and Care	T1001-1003 15 min units		
Adult Peer Supports	H0038 - 15 min units			Special Adolescent Substance Abuse Day Treatment	H2012-HA/HF Hour units		
Assertive Community Tx.	H0039 - 15 min units			Child & Adolescent Day Support (low intensity)	H2012-HA/HE/U1 Hour units		
Residential Services	H0043 - day units			Child & Adolescent Day Support (high intensity)	H2012-HA/HE/U2 Hour units		
				Adult Substance Abuse IOP	H2012-HB/HF Hour units		

Date first seen: _____ Date last seen: _____

Total # of visits used to date: _____

Est. # of session to complete treatment episode: _____

Projected start date for requested authorization: _____

_____ (Licensed Clinician Signature)

_____ (Printed Clinician Name)

_____ (Actual Service Provider Name)

_____ (Date)

Please Submit to:

Cenpatco Behavioral Health
 504 Lavaca, Suite 850
 Austin, TX 78701

Fax: 512-406-7215