

Mental Health Outpatient Request Form

Please check line of business for this form:

- BlueAdvantage (PPO)SM BlueCare Plus (HMO SNP)SM CoverKids
 BlueCareSM TennCare*Select*

Level of care requesting (case type): (please check the appropriate level of care).

- Partial hospitalization programming (PHP)
 PHP - Mental health primary
 PHP - Substance abuse primary
- Intensive outpatient programming (IOP)
 IOP - Mental health primary
 IOP - Substance abuse primary
- Comprehensive child and family therapy (CCFT)
 Continuous treatment team (CTT)
 Psychological testing (see other specific form)
 TMS (transcranial magnetic stimulation)
 Program of assertive community treatment (PACT)
 Outpatient routine psychiatry (no precert required if in network)
 Outpatient routine therapy (no precert required if in network)
 Applied behavior analysis (ABA) (see other specific form)
 Routine supported housing
 Enhanced supported housing
 Medically fragile supported housing
 BH respite
 Electro convulsive therapy (ECT)
 System of Support (SOS)
 Project Transition

Member number: _____

Member name: _____

Member date of birth: _____

Member contact number: _____

Date request sent: _____

**Initial: Yes or No

**Concurrent: Yes or No

**If concurrent, please list auth number and fill out remainder of this section and then skip to concurrent review and treatment/discharge planning section towards bottom of form.

**Auth number: _____

Provider name: _____

Provider phone: _____

Provider fax: _____

Place of service: on campus outpatient hospital, off campus outpatient hospital, office

Requesting clinician: _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Treating clinician: _____

Clinician provider ID #: _____

Clinician NPI #: _____

Clinician address: _____

Requested facility: _____

Facility provider ID #: _____

Facility NPI #: _____

Facility address: _____

Psychiatric ICD-10 diagnosis codes:

1) _____

2) _____

3) _____

4) _____

5) _____

Medical ICD-10 diagnosis codes:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Requested start date of service: _____

Units or number of days requesting: _____

Clinical information section

Date when member initiated request for this service: _____

(For initial review, please see other applicable sections below and fill out all that apply.)

Describe in detail the patient's current condition to include... (thorough mental status, behavioral symptoms)

Suicidal ideation? (plans/means/intent) Yes or No

Homicidal ideation? (plans/means/intent) Yes or No

Psychosis? Yes or No

Other symptoms/concerns:

Is there duty to warn? Yes or No

Describe any history of attempts (suicidal attempts, homicidal attempts or overall aggression towards others and/or property).

Precipitant:

Treatment history:

What is patient's baseline?

Why can the member not be treated in a lower level of care at this time?

Medications	Dose	Frequency	Dates	Outcome

Medication adherence? Barriers to adherence?

Urinary Drug Screen (UDS) and/or Blood Alcohol (BAL) results:

Fill out this section only if patient is under the age of 18.

Who has custody of patient?

Is there any current CPS/DCS involvement? Yes or No

Do any current symptoms/behaviors occur in school setting? Yes or No

Is the school involved in current treatment plan? Yes or No

Is the member involved with special education? Yes or No

Fill out this section only if patient has substance abuse issues.

note above referenced UDS and BAL

Drugs of choice	Amount of use	Frequency of use	Age of first use	Date of last use	Method of administration

Longest period of sobriety: _____

Vital signs: *Blood pressure: _____ *Heart rate: _____ *Temperature: _____

Is there history of seizures, DT's (delerium tremens) or blackouts? Yes or No

Current withdrawal symptoms:

Psychological and/or legal consequences of substance use:

Substance abuse treatment history:

Support group involvement:

Patient's triggers:

Fill out this section only if patient has eating disorder issues.

Patient height: _____

Patient weight: _____

% Ideal body weight (IBW): _____

Current BMI: _____

Orthostatic blood pressure: _____

Standing: _____

Sitting: _____

Pulse rate: _____

EKG, electrolytes, and other lab information:

Goal weight/BMI _____

Last known episode of bingeing/purging/withholding:

Triggers for bingeing/purging/withholding:

Precipitant(s):

Fill out this section only if patient needs sexual offender related services.

Presenting problem:

What is current involvement with legal system and/or DCS?

When was the last time these behaviors occurred?

In what setting do these behaviors occur?

Is the school setting involved in current treatment plan? Yes or No

Has a psychosexual assessment been completed prior to this request? Yes or No

If yes, please attach said assessment.

Fill out this section for concurrent review only, then skip down to treatment and discharge planning section.

What progress has been made since the last review in regards to symptoms, behaviors, diagnosis, etc?

Is there ongoing suicidal/homicidal ideations or psychosis? Yes or No

Medication changes:

If no progress, how will the treatment plan be changed?

Family involvement (phone, education, family sessions, visitations), please list details:

Treatment and Discharge Planning Section

List the goals necessary and attainable for the patient/family within requested treatment setting:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

What is the anticipated treatment plan for the patient in the requested level of care?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Are there any limitations for family participation in treatment (transportation, legal, etc.)? (If yes, please provide details.)

- 1) _____
- 2) _____
- 3) _____

Discharge plan:

Anticipated barriers to discharge:

Primary care physician name and efforts to coordinate care:

Signature of ordering clinician with credentials (required in order to process):

Date of signature: _____

Fax pre-certification numbers:

BlueAdvantage: 1-888-535-5243

BlueCare Plus: 1-866-325-6698

Bluecare/TennCare*Select*: 1-800-292-5311

CoverKids: 1-800-851-2491

Customer service numbers:

BlueAdvantage: 1-800-841-7434

BlueCare Plus: 1-800-299-1407

BlueCare: 1-800-468-9736

TennCare*Select*: 1-800-276-1978

CoverKids: 1-800-924-7141

