



# Medicare Advantage Outpatient Treatment Request

Fax completed form to: 866-949-4846 Fill out completely to avoid delays

Request Submission Date: \_\_\_\_\_

Request Type (Check one):  Standard  Expedited (additional information required below):

**Provider Attestation (Expedited Requests Only)**

Clinical justification for expedited review:

By signing below, I certify that applying the standard review timeframe for this service request may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Physician/clinician name: \_\_\_\_\_ Signature: \_\_\_\_\_

## Identifying Data

First: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Customer ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Request Authorizations

	Service	Code	# Units/Days requested	Service Start Date	Service End Date
1.					
2.					
3.					
4.					

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933152 04/2020 INT\_20\_85391\_C

## Provider Information

**Name** (program, facility or provider): \_\_\_\_\_ **NPI #:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**To whom should the authorization determination be sent? Name:** \_\_\_\_\_

**Phone:** (\_\_\_\_) \_\_\_\_\_ **Fax:** (\_\_\_\_) \_\_\_\_\_

**Other BH Provider(s):** \_\_\_\_\_

**Check one:**

- Member agreed to release of information to their PCP and/or other treating providers dated \_\_\_\_\_.
- Member has been informed for release of information and has declined

## Diagnosis ICD 10 Codes


## Psychotropic Medications

Medication	Previous or current?	Changed since last report?	Dosage	Frequency	Adherent?

## Clinical Narrative

*Provide information to support this request: symptoms, risk factors, social history, substance use history, etc.*

## Co-occurring Medical Conditions

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## Treatment History

*All levels of care*

Level of Care	# of distinct episodes/ sessions	Date of last treatment		Level of Care	# of distinct episodes/ sessions	Date of last treatment
Inpatient psychiatric				Inpatient Outpatient (IOP)		
Inpatient Substance Use Disorder				Outpatient psych (individual or group)		
Partial Hospitalization (PHP)				Outpatient substance use (individual or group)		

## Treatment Goals and Outcomes

*Complete fields below and/or attach current treatment plan*

Treatment Goals
1.
2.
3.
Objective outcome criteria by which goal will be measured:
1.
2.
3.

**Expected Outcome and Prognosis (check all that apply)**

- Return to normal functioning
- Expected improvement, anticipated less than baseline functioning
- Relieve acute symptoms, return to baseline functioning
- Maintain current status, prevent deterioration

**Discharge/Termination Plan (include estimated discharge date)**

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