CLEAR FORM

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:** _____

Indentifying 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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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

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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