Clinic Assigned Member Number ____________________ Please mark appropriate choice: ❍ Referral Request ❍ Authorization

Minnesota's Universal Outpatient Mental Health/Chemical Health Authorization Form

Patient Name: ____________________
Patient Address: ____________________
Subscriber Name: ____________________
Health Plan Name: ____________________
Health Plan/Group Number: ____________________
Member ID: ____________________
Patient DOB: ____________________
Is this treatment court-ordered? ❍ No ❍ Yes (If yes, submit order and evaluation)

Number of Sessions to date: __________ Frequency __________
Date 1st Visit (present episode of care) __________ Date of most recent visit __________
Release of information for payer signed: ❍ Yes ❍ No
Release of information for PCP signed: ❍ Yes ❍ No
Release of Information for other treating professionals signed: ❍ Yes ❍ No ❍ N/A
❍ Tx Plan or Summary sent to patient's PCP
❍ Patient/Parent/Guardian refused consent for release to PCP
❍ Patient states they have no PCP

Provider Name: ____________________
Degree/License Type: ____________________
Clinic Name: ____________________
Mailing Address & Fax: (see instructions) ____________________
Provider ID: ____________________
Clinic ID (If Applicable): ____________________
*Supervising Provider Name: ____________________
*Supervising Provider ID: ____________________
Provider Phone: ____________________
Provider Fax: ____________________

Prior Treatment- # Episodes in Past Year
MH: Outpatient ______ Inpatient ______ PHP ______ IOP ______
CD: Outpatient ______ Inpatient ______ PHP ______ IOP ______
Outcome: AMA discharge ______ Completed Treatment/still using ______
Completed Treatment/Sober ______ Active in CD Support Group ❍ Yes ❍ No

Current Symptoms:

Mood: ❍ Sad ❍ Elated ❍ Hopeless ❍ Low Energy ❍ Poor Concentration ❍ Angry ❍ Appropriate ❍ No Problem ❍ Other __________
Anxiety: ❍ Worry ❍ Panic ❍ Fearfulness ❍ Compulsive ❍ None ❍ Other __________
Thought: ❍ Delusions ❍ Hallucinations ❍ Disorganized Speech ❍ Obsessive ❍ Distractible ❍ No Problems ❍ Other __________
Behavior: ❍ Aggressive ❍ Truant ❍ Runaway ❍ Disorganized behavior ❍ Compulsive ❍ Hyperactive ❍ Other __________
Sleep Problems, Describe: __________ **Appetite Problems, Describe:** __________

Diagnosis: Tip: Use DSM-IV Codes; include all Axes.

Axis I Primary __________ **Axis II** __________
Secondary __________ **Axis III** __________

Axis IV
❍ Economic problems
❍ Housing problems
❍ Occupational problems
❍ Other psychosocial problems
❍ Problems accessing health services
❍ Problems related to interactions with legal/criminal system
❍ Problems related to social environment/school

Axis V (GAF) Current __________ Highest in last 12 months __________

Target Problems/Symptoms
____

Risk Assessment:

Suicidality:
❍ None
❍ Ideation
❍ Plan
❍ Intent w/o means
❍ Intent with means
❍ Ideation in past yr
❍ Attempt in past yr
❍ Family/peer history of completed suicide

Homicidality
❍ None
❍ Ideation
❍ Plan
❍ Intent w/o means
❍ Intent with means
❍ Ideation in past yr

If risk exists:
Client has contracted not to harm
❍ Self ❍ Others ❍ Declined to Contract

Hx Substance:
Abuse/ Dependence:
Assessed ❍ Yes ❍ No
Problem? ❍ Yes ❍ No
If yes, drugs of choice:
____
❍ Current abuse/dependence
❍ By family/significant other

Other Risk Factors:
❍ Hx physical/sexual abuse
❍ Child/elder neglect
❍ Anorexia ❍ Bulimia

Goals: Expected Outcome & Prognosis:

❍ Return to normal functioning
❍ Relieve acute symptoms, return to baseline functioning
❍ Expect improvement, anticipate less than normal functioning
❍ Maintain current status/prevent deterioration

Treatment Objectives: (List objectives directed at reducing symptoms and impairment in functioning.)

Progress Rating Scale: **N–New Objective** **1–Much Worse** **2–Somewhat Worse** **3– No Change** **4–Slight Improvement** **5–Great Improvement** **R–Resolved**

Measurable Objective	Intervention/Method(s) for Achieving Objective	Progress to Date	Resolution Date

If child/adolescent: Is family involved? ❍ Yes ❍ No Explain __________

Services:

Dates Requested: **from** __________ **to** __________
Number Requested: 90804: # ______ 90805: # ______ 90806: # ______ 90847: # ______
90853 # ______ 90862: # ______ 90870: # ______ Other: ______

Medication:

Has patient been evaluated for psychiatric meds. within last 12 months? ❍ Yes ❍ No ❍ Patient refused **Prescribing M.D. Name** __________
List all current medications/dose:
____

Estimated compliance with medication regime:
• Compliant with psychotropic as prescribed? ❍ Yes ❍ No ❍ n/a • Compliant with medical as prescribed? ❍ Yes ❍ No ❍ n/a

Provider's Signature and Date: __________ *Supervisor Signature and Date: __________
*Client/Patient Signature and Date: __________ *If required

Release Required on all Behavioral Healthcare Providers (BHP) Managed Patients

I understand the confidentiality of my records as protected by law. Information about me cannot be released without my consent. I understand I may revoke this consent at any time, and it will automatically expire without my revocation after one (1) year from the date of signature. I do not authorize release of this information by the recipient unless further release is specifically authorized.

I hereby give authorization for_____________________(provider name)_________________________to contact and inform BHP Intake of all medical information included in this treatment plan, and

I hereby give authorization for_____________________(provider name)_________________________to contact and inform my Primary Care Physician of all medical information included in this treatment plan; and

I hereby give authorization for BHP Intake to contact and inform my Primary Care Physician of all medical information included in this treatment plan.

Patient Signature/Date Signed:____ ______/______/______

INSTRUCTIONS

Clinic Assigned Member Number: This is an optional item that clinics/providers may use to record their internal account or reference number for the purpose of internally tracking submitted authorization forms.

Referral Request or Authorization Request: Check the appropriate box to indicate whether the document is being used to request authorization of services (including concurrent reviews for subsequent services) or to request a referral for services. A referral request is generally a request submitted by an out-of-network provider who is requesting that his/her services be covered under the patient's in-network benefits. Providers may need to check with the patient's health plan for specific requirements.

PATIENT/PROVIDER BLOCKS

Patient Address: Current address of patient, NOT subscriber's address. If the patient is a child who is in foster care, the patient address should reflect the foster care address.

Subscriber Name: Provide the name of the individual who is the subscriber of the insurance.

Health Plan Name: Provide the name of the health insurance company/plan.

Health Plan/Group Number: Provide the appropriate health plan/payer-assigned health plan or group number off of the patient's identification card.

Member ID: Provide the appropriate health plan/payer-assigned member identification number off of the patient's identification card.

Patient DOB: Provide the patient's date of birth.

Is this treatment court-ordered: Indicate whether the treatment is court-ordered and, if so, provide a copy of the order and the evaluation. The law requires that the health plan be given a copy of the court order and the behavioral care evaluation.

Provider Name: Provide the full name of the treating health care professional.

Degree/License Type: Provide the professional degree of the treating provider (e.g., M.D., Ph.D., Psy.D., M.S.W, M.A., R.N.); and provide the licensure type of the treating provider (e.g., LP, LICSW, LMFT, LACD, LPP).

Clinic Name: Provide the name of the clinic where the patient is being treated.

Mailing Address & Fax Number: Provide the mailing address, and a fax number, where authorizations/responses to this request should be sent. Note that this address may be different than the address where services will be provided.

Provider ID: Provide the appropriate health plan/payer-assigned provider identification number if available. Note that some health plans/payers may require this information to process this authorization request.

Clinic ID: Provide the appropriate health plan/payer-assigned clinic identification number where care is to be provided.

Supervising Provider Name: Provide the name of the supervising provider, <u>if required</u> for supervision or other appropriate circumstances.

Supervising Provider ID: Provide the health plan/payer-assigned provider identification number of the supervising provider, <u>if required</u> for supervision or other appropriate circumstances.

Provider Phone: Provide a phone number for the treating provider.

Provider Fax: Provide a fax number for the treating provider.

Number of Sessions to Date/Frequency: Indicate the total number sessions, to date, that this patient has been seen by you/your clinic; and, indicate the frequency of those sessions (e.g., weekly, monthly, quarterly, etc.).

Release of Information for payer signed: Indicate whether the patient has signed a release of information form allowing information to be shared with his/her insurer/payer. Note that some health plans/payers (e.g., BHP) may have specific release of information requirements for initial requests. Providers may need to check with the patient's insurer/health plan for specific requirements.

Release of Information for PCP signed: Indicate whether the patient has signed a release of information form allowing information to be shared with his/her primary care provider (PCP). The attached release (page 2) is specifically required for BHP. Providers may need to check with the patient's insurer/health plan for other specific requirements.

Release of Information for other treating professionals signed: Indicate whether the patient has signed a release of information form allowing information to be shared with his/her other treating professionals. Providers may need to check with the patient's insurer/health plan for specific requirements.

Information Release Actions: Place a check mark before those statements that are true (TX plan or Summary sent to patient's PCP; Patient/Parent/Guardian refused consent for release to PCP; patient state they have no PCP).

Prior Treatment: If available, indicate for both mental health (MH) and chemical dependency (CD) treatment, the number of episodes of outpatient, inpatient, partial hospitalization program (PHP), or intensive outpatient therapy (IOP) treatment provided in the past year.

CURRENT SYMPTOMS BLOCK

Identify the symptoms that the patient is currently experiencing. Attach additional sheet if necessary.

DIAGNOSIS BLOCK

Axis I: List the appropriate diagnosis code(s) for primary and secondary diagnoses, and other diagnoses as appropriate.

Axis II: List the appropriate diagnosis code(s).

Axis III: List the appropriate diagnosis code(s)

Axis IV: Identify patient stressors as appropriate.

Axis V (GAF): Provide the current GAF and the highest GAF within the last 12 months.

Target Problems/Symptoms: Summarize the patient's target problems/symptoms (attach additional sheet if necessary).

RISK ASSESSMENT BLOCK

Specify the patient's risk factors.

GOALS: EXPECTED OUTCOME & PROGNOSIS BLOCK

Indicate which of the four categories (return to normal functioning; relieve acute symptoms, return to baseline functioning; expect improvement, anticipate less than normal functioning; or, maintain current status/prevent deterioration) best describes the expected outcome and prognosis.

TREATMENT BLOCK

For each measurable objective identified (e.g., improve sleep patterns for three-five nights), identify the interventions/methods for achieving the objective (e.g., encourage exercise, provide and give instructions in use of sleep journal), the progress to date in achieving the objectives (using the progress rating scale provided), and the targeted resolution date.

SERVICES BLOCK

Dates Requested: Indicate the range of dates for which services are being requested (from date and to date).

Number Requested: Provide the number of sessions/visits requested by procedure code. Requests for psychological testing, and any other services that are not listed under the codes provided, should be included on the "other" line with the appropriate service code.

MEDICATION BLOCK

Has patient been evaluated for psychiatric medication within last 12 months? Indicate whether the patient has been evaluated for psychiatric medication within the last 12 months, or if patient refused to respond.

Prescribing MD Name(s): Provide the name(s) of the prescribing physician(s) for patient's current medication(s).

Current Medications & Dosages: For initial requests, provide a list of all psychotropic and medical prescriptions, with dosages, the patient currently is using. For subsequent requests/reviews, list any changes to medications or dosages (attach additional sheet as necessary).

Estimated compliance with medication regime: Evaluate the patient's compliance with his/her medication regime for both psychotropic and medical prescriptions, as applicable.

Patient Signature: Obtain the patient's signature, if required. Note that some health plans/payers may require the patient's signature before authorization can be provided. Providers may need to check with the patient's health plan for specific requirements.