

Medicare Advantage Outpatient Behavioral Health Treatment Request



Fax this completed form to **866-949-4846**.

Date ___/___/_____

Request type

Standard

Expedited

Clinical justification for expedited review _____

Provider attestation for expedited requests only

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

Provider _____ Signature _____

Identifying data

Member name _____

Member ID _____ Date of birth ___/___/_____ Gender Male Female Nonbinary

Address _____

City _____ State _____ ZIP _____

Check one

Member agreed to the release of information to their primary care provider or other treating providers

Member has been informed about the option to release information and has declined

Provider information

Provider, facility or program name _____

National Provider Identifier _____

Phone _____ Fax _____

To whom should the authorization determination be sent? Name _____

Phone _____ Fax _____

Current behavioral health provider _____

Request authorization(s)

Service	Code	Number of units/ days requested	Service start date	Service end date

Diagnosis ICD-10 codes

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Psychotropic medications

Medication	Previous or current	Changed since last report	Dosage	Frequency	Adherent

Clinical narrative

Provide information to support this request, including symptoms, risk factors, social history or substance abuse history.

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Co-occurring medical conditions

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Treatment history

Provide treatment history for all levels of care.

Psychotropic medications

Level of care	Number of distinct episodes or sessions	Date of last treatment	Level of care	Number of distinct episodes or sessions	Date of last treatment
Inpatient psychiatric			Inpatient outpatient		
Inpatient substance use disorder			Outpatient psychiatric – individual or group		
Partial hospitalization			Outpatient substance abuse – individual or group		

Treatment goals and outcomes

Complete the fields below or attach current treatment plan.

Treatment goals

Objective outcome criteria by which goal will be measured

Expected outcome and prognosis (check all that apply)

<input type="checkbox"/> Return to normal functioning	<input type="checkbox"/> Relieve acute symptoms, return to baseline functioning
<input type="checkbox"/> Expected improvement, anticipated less than baseline functioning	<input type="checkbox"/> Maintain current status, prevent deterioration

Discharge and termination plan

Estimated discharge date ____/____/____

Discharge plan