SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.866.694.3649

magnolia health®

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID #_____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary _____

Secondary_____

Tertiary_____

Additional_____

Additional_____

Has contact occurred with PCP? ☐ Yes ☐ No

Date first seen by provider/agency_____

Date last seen by provider/agency_____

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT).

1. In the last 30 days, have you/your child had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you/your child had problems with fears and anxiety? ☐ Yes (5) ☐ No (0)
3. Do you/your child currently take mental health medicines as prescribed by your doctor? ☐ Yes (0) ☐ No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you or your child? ☐ Yes (5) ☐ No (0)
5. In the last 30 days, have you/your child gotten in trouble with the law? ☐ Yes (5) ☐ No (0)
6. In the last 30 days, have you/your child actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
   ☐ Yes (0) ☐ No (5)
7. In the last 30 days, have you/your child had trouble getting along with other people including family and people out the home?
   ☐ Yes (5) ☐ No (0)
8. Do you/your child feel optimistic about the future? ☐ Yes (0) ☐ No (5)

Children Only

9. In the last 30 days, has your child had trouble following the rules at home or school? ☐ Yes (5) ☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)? ☐ Yes (5) ☐ No (0)

INDICATE PREVIOUSLY RECEIVED SERVICES:

☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy ☐ Community Support Services (H0036) ☐ Targeted Case Management

Please indicate if the patient has been diagnosed with Autistic Spectrum Disorder and/or has had inpatient hospitalizations?

☐ Autistic Spectrum Disorder ☐ Inpatient Hospitalizations

Please list all current medications: If prescribed medication, is member compliant? ☐ Yes ☐ No

Therapeutic Approach/Evidence Based Treatment Used

LEVEL OF IMPROVEMENT TO DATE

☐ Minor ☐ Moderate ☐ Major ☐ No progress to date ☐ Maintenance treatment of chronic condition

Barriers to Discharge

CURRENT SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Hyperactivity/Inattention	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐

Other (include severity):_____

Member Name _____

PLEASE INDICATE HISTORICAL SYMPTOMOLOGY DATA

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐

Last Date of substance use:_____

	N/A	Mild	Moderate	Severe
Physical Health	☐	☐	☐	☐
Work/School	☐	☐	☐	☐

Drug(s) of Choice:_____

RISK ASSESSMENT

Suicidal: ☐None ☐Ideation ☐Planned ☐Imminent Intent ☐History of self-harming behavior

Homicidal: ☐None ☐Ideation ☐Planned ☐Imminent Intent ☐History of self-harming behavior

Safety Plan in place? (If plan or intent indicated): ☐Yes ☐No

CURRENT MEASUREABLE TREATMENT GOALS

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

Behaviroal Health Outpatient Servies (billed as CPT codes)	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
☐ Individual Therapy				
☐ Family Therapy				
☐ Group Therapy				
Case Management (T1017)				
☐ Adult (15 minute units)				
☐ Child (15 minute units)				
Psychosocial Rehabilitation (H2030)				
☐ Adult (15 minute units)				
☐ Senior (15 minute units)				
☐ Community Support Services (H0036) (15 minute units)				
☐ Assertive Community Treatment (H0039) (15 minute units)				
☐ Day Treatment (child) (H2012) (per hour)				
☐ Wraparound Facilitation (H2021) (15 minute units)				

If you are a nonparticipating provider only, please indicate here any additional codes you are requesting an authorization for. Other code(s) requested:

☐		
☐		
☐		

PROVIDER NAME _____ DATE _____

PROVIDER SIGNATURE _____

SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.866.694.3649