Treatment Continuation Request Form Behavioral Health Unit

Please fax to the Behavioral Health Unit: 1.866.616.6255

** All sections must be completed for timely approval.*

Patient Name: _____

Member ID: _____ Date of Birth: _____

Provider Name: _____

Phone Number: _____ NPI #: _____

Address: _____

_____

Date of Evaluation Visit for current Episode of Care: _____

Is this request urgent? ☐ Yes ☐ No

ASSESSMENT:

Clinical Disorders/Syndromes Diagnoses Code: _____

Personality Disorders/Intellectual Disabilities Diagnoses Code: _____

CURRENT MEDICATIONS:

☐ Anti-Psychotic ☐ Anti-Anxiety ☐ Anti-Depressant ☐ None

☐ Hypnotic ☐ Mood Stabilizer ☐ Psycho-Stimulant

☐ Medical ☐ Other/Comments: _____

RISK ASSESSMENT:

Suicidal Ideation	☐	Ideation	☐	Plan	☐	Intent	☐ None
Homicidal Ideation	☐	Ideation	☐	Plan	☐	Intent	☐ None

SYMPTOMS: (IF PRESENT, CHECK DEGREE)

	Mild	Moderate	Severe
Depressed Mood	☐	☐	☐
Anxiety	☐	☐	☐
Anhedonia	☐	☐	☐
Panic Attacks	☐	☐	☐
Low Energy	☐	☐	☐
Inattention	☐	☐	☐
Hopelessness	☐	☐	☐
Impulsive	☐	☐	☐
Somatoform	☐	☐	☐
Bingeing/Purging	☐	☐	☐
Factitious Problems	☐	☐	☐
Restricting Food Intake	☐	☐	☐
Social Isolation	☐	☐	☐
Hyperactive	☐	☐	☐
Self-Mutilation	☐	☐	☐
Hallucination	☐	☐	☐
Sleep Disturbance	☐	☐	☐
Delusions	☐	☐	☐
Mood Swings	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐
No Symptoms	☐		

SUBSTANCE ABUSE/ADDICTIONS

- ☐ Active Drug Use
- ☐ Cravings
- ☐ Drug Seeking Behavior
- ☐ Guilt/Remorse/Shame
- ☐ Preoccupation with Getting High
- ☐ Preoccupation with Gambling
- ☐ Abuse in Remission
- ☐ None

Is this patient on mental health or chemical dependency disability? ☐ Yes ☐ No

Have you contacted the patient's PCP? ☐ Yes ☐ No

Have you contacted any other health care provider? ☐ Yes ☐ No

If "Yes", list who? _____

Other Provider: _____

INTERVENTIONS & GOALS USED IN TREATMENT:

1. _____

_____

Time Frame to Complete: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other

2. _____

_____

Time Frame to Complete: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other

3. _____

_____

Time Frame to Complete: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other

SPECIFIC SERVICES REQUESTED AND NUMBER OF SERVICES REQUESTED:

Code	No. of Services	Code	No. of Services	Code	No. of Services
90791		90837		90785	
90792		90833		90846	
90832		90836		90847	
90834		90838		90853	
E&M Code: _____		No. of Service: _____			

FREQUENCY OF APPOINTMENTS SCHEDULE:

☐ Weekly ☐ Twice a month ☐ Monthly Other: _____

LEVEL OF IMPROVEMENT TO DATE:

☐ None ☐ Minor ☐ Moderate ☐ Major

ADDITIONAL SYMPTOMS, FUNCTIONING LEVEL AND COMMENTS:

Provider Signature: _____ Date: _____