MASSACHUSETTS

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Treatment Request Form: Outpatient Mental Health and Substance Abuse services

Fax to: 1-888-641-5199

For BCBSMA/EDS Employees & Dependents, fax to: 1-888-608-3693

Use to request additional services prior to 8th visit for Federal Employee Program members, and prior to 12th visit for all other members.

Member Information (Verify eligibility before rendering services)

Today's Date: _____

Patient Name: _____

BCBSMA Member ID: _____

Date of Birth: (mm/dd/YYYY)

Service Requested: ☐ Individual ☐ Group

☐ OP ECT ☐ Couples ☐ Family

Provider Information

NPI: _____

BCBSMA ID: _____

TIN if not contracted: _____

Group name: _____

Group address: _____

_____

Clinician name: _____

Clinician discipline: _____

Phone: ( )

Fax: ( )

Our policy requires that we handle PHI in accordance with HIPAA protections. Is this fax number 'secure' for the receipt/transmission of PHI? ☐ Yes ☐ No

Is this out-of-network request? ☐ Yes* ☐ No

**** If yes, please complete an out-of-network request form (Fax-on-demand document 953)***

Request for Sessions

Start date of treatment episode: _____

Start date for current request: _____

# of sessions used this year: _____

# of sessions requested on this auth: _____

DSM-IV Diagnosis

	Primary	Co-occurring
Axis I:	☐☐☐-☐☐	☐☐☐-☐☐
		☐☐☐-☐☐
Axis II:	☐☐☐-☐☐	☐☐☐-☐☐
		☐☐☐-☐☐

Axis III: _____

Is medical condition(s) relevant to treatment? ☐ Yes ☐ No

Is compliance w/ PCP regimen a problem? ☐ Yes ☐ No

Axis IV: ☐ mild ☐ moderate ☐ severe

Axis V: Current GAF _____

Highest in last year _____

Have you communicated with patient's PCP? ☐ Yes ☐ No ☐ Patient doesn't have PCP

Current Risk Indicators (check all that apply

☐ Suicidal ideation ☐ Active ☐ Passive ☐ Plan/intent

☐ Prior suicide attempt(s): Date: _____

☐ Required hospital stay?

☐ Self-injurious behavior Specify: _____

☐ Eating Disorder

☐ Assaultive/aggressive

☐ Active sub. abuse/depend. If yes, drug of choice? _____

☐ Past sub. abuse treatment Date: _____

☐ Prior inpatient hospitalization # in past 3 years: _____

☐ Homicidal Ideation

Other Symptoms (check all that apply):

☐ Anxiety/panic ☐ Depression ☐ Paranoia

☐ Runaway ☐ Psychosis ☐ Trauma/abuse

☐ Impulsive/manic behavior ☐ Peer/relationship problems

☐ Neuro-vegetative ☐ Obsessive compulsive

☐ Oppositional/defiant ☐ Sexually inappropriate

☐ Other (specify): ☐ Thought disorder

Current Psychotropic Medications & Dosages

List all Rx & Dosages (write "none" if no Rx) _____

_____

_____

Name of Prescriber: _____

Prescriber is: ☐ Psychiatrist ☐ RNCS ☐ PCP ☐ Other

Do you coordinate treatment w/prescriber? ☐ Yes. Freq.: _____ ☐ No. Why: _____

Does the patient regularly take medications as prescribed?

☐ Always ☐ Usually ☐ Seldom ☐ Never ☐ Unknown

Does the patient report Rx side effects? ☐ Yes ☐ No

Do you plan to refer the patient for Rx eval? ☐ Yes ☐ No

If no, why:

Treatment Status

	Focus of Treatment	Improved	Same	Worse
1.		☐	☐	☐
2.		☐	☐	☐
3.		☐	☐	☐
4.	Symptoms	☐	☐	☐
5.	Relationship with significant other/ children	☐	☐	☐
6	Ability to function at home/work/school	☐	☐	☐

Specific Goals for treatment:

1. _____
2. _____
3. _____

Anticipated discharge from treatment date: _____