Behavioral Health and Substance Use of Nonacute Services (Outpatient Treatment) Request Form

Fill out completely to avoid delays. Once complete, submit via our website at **https://www.availity.com*** or fax this form to **1-844-462-0026**.

Identifying data	
Patient's name:	
Medicaid ID:	DOB:
Patient's address:	
Provider information	
Provider name:	
Tax ID:	
Phone:	Fax:
PCP name:	PCP NPI:
Name of other behavioral health providers:	

ICD-10-CM diagnoses		

Medications (Please indicate changes since last report.)		
Current medications	Dosage	Frequency

Current risk factors	
Suicide	☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm self
Homicide	☐ None ☐ Ideation ☐ Intent without means ☐ Intent with means ☐ Contracted not to harm others
Physical or sexual abuse, or child/elder neglect	☐ Yes ☐ No If yes, patient is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in the family

* Availity, LLC is an independent company providing administrative support services on behalf of Healthy Blue.

https://provider.healthybluemo.com

BMOPEC-0083-20 August 2020

Requested service authorization				
Procedure code	Number of units	Frequency	Requested start date	Estimated number of units to complete treatment

Symptoms (Include those that are the focus of current treatment.)

Progress since last review

Functional impairments/strengths (for example, interpersonal relations, personal hygiene, work/school, etc.)

Recovery environment (Please describe support system and level of stress.)

Engagement/level of active participation in treatment

Housing

Co-occurring medical/physical illness

Family history of mental illness or substance abuse

Treatment goals		
Goal	Type of service	Expected achieve date
1.		
2.		
3.		
4.		
5.		

Discharge plan and estimated discharge date

Expected outcome and prognosis
☐ Return to normal functioning
☐ Expect improvement, anticipate less than normal functioning
☐ Relieve acute symptoms, return to baseline functioning
☐ Maintain current status, prevent deterioration
Attach summary sheet(s) of any applicable assessments. Psychological/neuropsychological testing requests require a separate form.

Treatment plan coordination	
I have requested permission from the member/member's parent or guardian to release information to the PCP/psychiatrist.	☐ Yes ☐ No If no, rationale why this is appropriate:
Treatment plan was discussed with and agreed upon by the member/member's parent or guardian.	☐ Yes ☐ No
Provider signature:	
Date:	