

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:						
Maratic and ID:		L D.O	.D.			
Medicaid ID:		טט	DOB:			
Patient's address:						
Provider information						
Provider name:						
Tax ID:						
Phone:		l Fax	Fax:			
PCP name:		PC	PCP NPI:			
		. •				
Name of other behavioral health pr	oviders:	•				
ICD-10-CM diagnoses	Π			T		
Medications (Please indicate char	l naes since last reni	ort)				
Current medications	iges siriee last rep		Dosage		Frequency	
Out on the dicalions			oago		1 roquonoy	
Current risk factors						
Suicide	☐ None		□ Ideation		ntent without means	
☐ Intent with		ans	☐ Contracted not to harm self			
Homicide	□ None		☐ Ideation ☐ Intent without means			
☐ Intent with mea		ans	☐ Contracted not to harm others			
Physical or sexual abuse, or	☐ Yes ☐ No					
child/elder neglect						
	If yes, patient is:		☐ Victim ☐ Perpetrator ☐ Both			
			□ Neither h	out abuse exis	ets in the family	

https://provider.healthybluemo.com

Healthy Blue is a Medicaid product offered by Missouri Care, Inc., a MO HealthNet Managed Care health plan contracting with the Missouri Department of Social Services. Healthy Blue is administered statewide by Missouri Care, Inc. and administered in the Kansas City service region by Missouri Care, Inc. in cooperation with Blue Cross and Blue Shield of Kansas City. Missouri Care, Inc. and Blue Cross and Blue Shield of Kansas City are both independent licensees of the Blue Cross and Blue Shield Association.

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

Requested service authorization							
Procedure code	Number of units	Frequency	Requested start date	Estimated number of units to complete treatment			
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Symptoms (Include those that are the focus of current treatment.)							
Progress since la	ast review						
Functional impairments/strengths (for example, interpersonal relations, personal hygiene, work/school, etc.)							
Recovery enviro	nment (Please desc	ribe support syst	em and level of stress.)				
Engagement/leve	el of active participa	ation in treatme	nt				
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 of	late					
Expected outcome and prognosis						
☐ Return to normal functioning						
☐ Expect improvement, anticipate less than r	normal functioning					
☐ Relieve acute symptoms, return to baseline	e functioning					
☐ Maintain current status, prevent deteriorati	on					
Attach summary sheet(s) of any applicable as	ssessments.					
Psychological/neuropsychological testing requests require a separate form. Treatment plan coordination						
I have requested permission from the	☐ Yes ☐ No					
member/member's parent or guardian to						
release information to the PCP/psychiatrist.	If no, rationale why this is appropriate:					
Treatment plan was discussed with and agreed upon by the member/member's	☐ Yes ☐ No					
parent or guardian.						
Provider signature:						
Date:						