YouthCare
HealthChoice Illinois

SUBMIT TO
Utilization Management Department
PHONE 844-289-2264 | FAX 844-989-0154

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing. ALL SECTIONS MUST BE COMPLETED.

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

First date seen by provider/agency_____

Last seen by provider/agency_____

SPMI/SED ☐ Yes ☐ No

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT WITHIN 30 DAYS OF SUBMISSION.).

1. In the last 30 days, have you had problems with sleeping or feeling sad?	☐ Yes (5)	☐ No (0)
2. In the last 30 days, have you had problems with fears and anxiety?	☐ Yes (5)	☐ No (0)
3. Do you currently take mental health medicines as prescribed by your doctor?	☐ Yes (5)	☐ No (0)
4. In the last 30 days, has alcohol or drug use caused problems for you?	☐ Yes (0)	☐ No (5)
5. In the last 30 days, have you gotten in trouble with the law?	☐ Yes (5)	☐ No (0)
6. In the last 30 days, have you 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 had trouble getting along with other people including family and people out the home? ☐ Yes (5) ☐ No (0)		
8. Do you feel optimistic about the future?	☐ Yes (0)	☐ No (5)
Children Only:		
9. Are you currenlty employed or attending school?	☐ Yes (0)	☐ No (5)
10. In the last 30 days, have you been at risk of loosing your living situation?	☐ Yes (0)	☐ No (5)
Adults Only:		
11. Are you currenlty employed or attending school?	☐ Yes (0)	☐ No (5)
12. In the last 30 days, have you been at risk of loosing your living situation?	☐ Yes (5)	☐ No (0)

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

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

	Mild	Moderate	Severe		Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	Hyperactivity/Inattn.	☐	☐	☐
Decreased Energy	☐	☐	☐	Irritability/Mood Instability	☐	☐	☐
Delusions	☐	☐	☐	Impulsivity	☐	☐	☐
Depressed Mood	☐	☐	☐	Hopelessness	☐	☐	☐
Hallucinations	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐
Angry Outbursts	☐	☐	☐	Other (include severity): _____			

_____Member Name

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

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

Last Date of Substance Use:_____

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

Drug(s) of Choice:_____

RISK ASSESSMENT

Suicidal: ☐ None ☐ Ideation Date of last episode _____ ☐ Planned ☐ Imminent Intent ☐ History of self-harming behavior

Homicidal: ☐ None ☐ Ideation Date of last episode _____ ☐ Planned ☐ Imminent Intent ☐ History of harm to others

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

If prescribed medication, is member compliant? ☐ Yes ☐ No

CURRENT MEASURABLE TREATMENT GOALS

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

	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Requested end date for this auth (Not to exceed 6 months)
BH OP SERVICES (BILLED WITH CPT CODES)				
☐ Individual Therapy (90832, 90834, 90837)				
☐ Group Therapy (90853)				
☐ Family Therapy (90847, 90849)				
CMHC ONLY				
☐ Case Management T1016 (15 min units) ☐ Check here if member has exhausted the allowed 200 lifetime units				
☐ Individual/Group/Family Therapy H0004 (15 min units)				
☐ Assertive Community Treatment H0039 (15 min units)				
☐ Crisis Intervention H2011 (15 min units) Must notify within 48 hours of each encounter. ☐ Check here if member has exhausted the allowed 360 lifetime units since 12/01/2018				
☐ Community Support H2015 (15 min units) ☐ Check here if member has exhausted the allowed 360 lifetime units since 12/1/2018				
☐ Community Support Team H2016 (15 min units) ☐ Check here if member has exhausted the allowed 360 lifetime units since 12/1/2018				
☐ Psychosocial Rehabilitation H2017 (15 min units) ☐ Check here if member has exhausted the allowed 800 lifetime units				

IF YOU ARE A NONPARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR. OTHER CODES (REQUESTED):

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Additional Information?

Clinician Signature Date

Clinician Signature Date

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PLEASE ATTACH IM – CAT