NEW AVENUES / MBHN: Medication Management Review – Authorization Request

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For Psychiatry Use Only **When to submit this form:**
This form replaces the ICA & may be used to request Medication Mgmt Sessions – 90862 & 90805 only
If requesting more than 8 sessions or other codes, i.e. 90807, please submit an OTR form

I. Demographics: Client's Name:_____ DOB #:_____

Address:_____ Policy ID:_____

_____ City, St Zip:_____

Home Phone:_____ Work Phone:_____

III. Risk Assessment:

Suicide Risk: ❒ None ❒ Low ❒ Moderate ❒ High
Within the Past 3 Months: ❒ Ideation ❒ Intent ❒ Plan ❒ Means ❒ Attempt
Date:_____ Describe:_____
_____

Homicide Risk: ❒ None ❒ Low ❒ Moderate ❒ High
Within the Past 3 Months: ❒ Ideation ❒ Intent ❒ Plan ❒ Means ❒ Attempt
Date:_____ Describe:_____
_____

Physical Violence: ❒ None ❒ Low ❒ Moderate ❒ High
Within the Past 3 Months: ❒ Ideation ❒ Intent ❒ Plan ❒ Means ❒ Attempt
Date:_____ Describe:_____
_____

IV. Chemical Abuse/Dependency:

Non-User/Abstainer	❒ Yes	❒ No	Self Medication	❒ Yes	❒ No
Experimental User	❒ Yes	❒ No	Loss of Control	❒ Yes	❒ No
Social/Recreational User	❒ Yes	❒ No			

Describe: _____

V. Treatment History:

			Discharge:		
Psychiatric:					
Inpatient	❒ Yes	❒ No	❒ <30 Days	❒ <1 Year	❒ >1 Year ago
Outpatient	❒ Yes	❒ No	❒ <30 Days	❒ <1 Year	❒ >1 Year ago
Med Management	❒ Yes	❒ No	❒ <30 Days	❒ <1 Year	❒ >1 Year ago
Substance/Chemical:					
Detox	❒ Yes	❒ No	❒ <30 Days	❒ <1 Year	❒ >1 Year ago
Rehab	❒ Yes	❒ No	❒ <30 Days	❒ <1 Year	❒ >1 Year ago
Outpatient	❒ Yes	❒ No	❒ <30 Days	❒ <1 Year	❒ >1 Year ago

VI. DSM-IV Diagnosis:

AXIS I: _____ Description: _____
AXIS II: _____ Description: _____
AXIS III: _____
AXIS IV:_____
AXIS V: (current GAF): _____AXIS V: (past year GAF): _____

VII. Medication & Lab Tests:

Compliant with Medication: ❒ Yes ❒ No
List side effects (if any): _____
_____
_____

All Medications (list in order by prescription date):

Name of medication:	Dose:	Frequency:	Start Date:	End Date:	Prescribing MD:

XIII. Provider Coordination of Care with PCP:

❒ Patient has signed consent form ❒ Patient declined to sign consent form
❒ Provider has not discussed consent form with Patient
Communicated with PCP by: ❒ Verbal ❒ Written Date of communication with PCP: _____

VIII. Frequency & Duration of Care:

First Appointment Date: _____ Last Appointment Date: _____

❒ ____ 99213 (formerly 90862) ❒ ____ 99214 (formerly 90805) ❒ ____Other: _____

Frequency: ❒ Monthly ❒ Quarterly ❒ Annually ❒ Other, Explain: _____

Number of Sessions Requesting for the next twelve (12) months: _____

Date this authorization should begin: _____

Provider's Name (Print):_____ Degree:_____

Provider's Signature: Date Signed:_____