NEW AVENUES / MBHN: Outpatient Treatment Report – Authorization Request

Employee Assistance Program · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925-5730 · Fax: (574) 271–5980
Midwest Behavioral Health Network · P.O. Box 360, South Bend, IN 46624 · Phone: (866) 925-5730 · Fax: (574) 271–5980

Fax to MBHN before member's authorization expires. Only Page 1 required for treatment to be completed within a case total of 20 visits.

I. Demographics: Date of Request: _____

Client Name: _____ Birth Date: _____ Policy ID _____

Health Plan: _____ Provider's Agency: _____

Provider Name (Print) _____ Provider Signature _____

II. Medication: (List all psychotropic & other medications) **Not Assessed** ❒

Has the patient been evaluated for medication? ■ Yes ❒ No Prescribing Physician: _____

Current Medication: ❒ None ❒ Psychotropic ❒ Medical ❒ Other: _____

Medication	Dosage/Frequency	Start Date	Medication	Dosage/Frequency	Start Date
①			⑤		
②			⑥		
③			⑦		
④			⑧		

Patient is compliant with medications: ❒ Yes ❒No ❒ Partial compliance

❒ This patient has not been evaluated for medications, but am recommending evaluation: ❒with PCP ❒with a Psychiatrist

III. Treatment Focus:
WRITE IN BELOW:
What realms of distress, symptoms, and/or impairment require continued treatment? For each realm, describe the problem(s) to be addressed in treatment as related to the diagnosis. If the realm is not affected, state "Not Applicable".

	Indicate Level of Distress/Impairment (1 - Severe, 2 - Significant, 3 - Moderate, 4 – Mild)	**Indicate Progress to Date** (1 - No Change, 2 - Mild Change, 3 - Moderate Change, 4 - Pronounced Change, 5 - Problem Resolved)
Psychological /Emotional Symptoms	0-Not Applicabl	0-Not Applicable
Physical Symptoms: Changes in appetite, sleep, energy or somatic concerns	0-Not Applicabl	0-Not Applicable
Behavioral Disturbances/Concerns	0-Not Applicabl	0-Not Applicable
Relationship Issues	0-Not Applicabl	0-Not Applicable
Cognitive Functioning	0-Not Applicabl	0-Not Applicable
ADL/Occupational/School Performance	0-Not Applicabl	0-Not Applicable
Substance Abuse/Compulsive Maladaptive Behaviors	0-Not Applicabl	0-Not Applicable
List Any Other Complicating Factors or Stressors:	0-Not Applicable	0-Not Applicable

IV. ICD 10 Codes (required)

I: _____ Description: _____

II: _____ Description _____

III: _____ Description _____

Co-morbid Condition(s): _____

Presence of Risk Factors:
❒Trauma: Recent or Historical
❒Abuse of alcohol, prescribed or non-prescribed medications, or use of illegal substances
❒Suicide ideation/intent/ attempts within last 90 days
❒Homicidal Ideation/intent/attempts within last 90 days
❒Experience of Serious Loss(es) within last 12 months
❒Other factors

(Required Field to Complete)

V. Provider Coordination of Care with PCP:
Patient was offered a consent form to coordinate care with PCP? ❒ Yes ❒ No Patient agreed? ❒ Yes ❒ No
If yes, date communication occurred _____
by: ❒ Verbal ❒ Written
If no communication has occurred within the last year indicate reason: ❒ No attempt has been made by this provider.
❒ Provider attempted with no success.

VI. Request for Approval of Visits:

Procedures Codes	# Units	Start Date	End Date
90834 / 90837			
90846 / 90847			
90853			
IOP - MH			
IOP - SA			
List Other Codes:			

If treatment is to be completed within a case total of 20 visits, fax Page 1 only to MBHN.
If treatment is expected to be more than a case total of 20 visits, including visits requested in VIII B., Pages 1 & 2 required.
MBHN Fax: 574-271-5980

Fax to MBHN: 574-271-5980 Tele: 866-925-5730

Client Name: _____

Page 2 Required for Patients in treatment more than a total of 20 visits, including visits requested in VIII. B.

VII. Current Treatment Plan:

A. **GOAL #1:** _____

GOAL #2: _____

GOAL #3: _____

B. Treatment Modalities: ❒ **Individual** ❒ **Family** ❒ **Group** ❒ **IOP-MH** ❒ **IOP-SA** ❒ **Medication Management** ❒**Other**

C. Frequency: ❒ **Weekly** ❒ **2 times/week** ❒ **3 times/week** □ **Bi-weekly** ❒ **Monthly** ❒ **Quarterly** ❒**As needed** ❒ **Other**

D. **Progress: What are your measures of progress?** Example: Frequency of panic attacks, Number of days of sobriety, Number of hours of sleep, etc.

_____

_____

_____

E. If progress has been limited as demonstrated by lack of improvement in GAF score, minimal symptom relief, lack of response to treatment, what are the reasons?

F. Are there any barriers or mitigating circumstances affecting progress?

G. Is patient compliant with Treatment Plan, with medications, with assignments, and with appointments? ❒ **Yes** □ **Partial** ❒**No - If "No" Describe Patient motivation or resistance levels.**

H. What methods, treatment modalities, or approaches are you using during proposed next phase of treatment? (E.g.: Cognitive Behavioral, EMDR, DBT, Family Therapy)

I. What outcomes are you expecting? (check all that apply)

❒ Symptom reduction & discharge from active treatment.

❒ Return to highest level of functioning before onset of current problem(s) & discharge from active treatment.

❒ Transfer to self-help group or other support services & discharge from active treatment.

❒ Provide ongoing supportive counseling in order to maintain stabilization of symptoms and functioning.

J. Is Treatment Plan consistent with APA or nationally recognized Clinical Guidelines? ❒Yes ❒No

VIII. Comprehensive Treatment Planning:

A. Has your Treatment Plan been coordinated with any other treating Provider? ❒ **PCP** ❒**Psychiatrist** ❒**Treatment Program** ❒**Other**

Are you recommending any additional services such as:

❒**Psychiatric Consultation** ❒**Psychological Testing** ❒**EMDR Consultation** ❒ **Substance Abuse Assessment** ❒ **Medical Evaluation/Consultation** ❒**Self-Help Groups**

B. Expected Date of Completion (Month/Year)**:** **Expected total number of additional sessions to complete treatment?**

PROVIDER'S SIGNATURE:_____ **AGENCY:** _____ **DATE SIGNED:** _____

Service location (address)_____