coordinated care

SUBMIT TO
Coordinated Care
Utilization Management Department
1145 Broadway, Suite 300
Tacoma, WA 98402
Phone: 1.877.644.4613 FAX 1.866.270.4489

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

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

Date first seen by provider/agency_____

Date last seen by provider/agency_____

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

1. In the last 30 days, have you/your child had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you/your child had problems with fears and anxiety? ☐ Yes (5) ☐ No (0)
3. Do you/your child currently take mental health medicines as prescribed by your doctor? ☐ Yes (0) ☐ No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you or your child? ☐ Yes (5) ☐ No (0)
5. In the last 30 days, have you/your child gotten in trouble with the law? ☐ Yes (5) ☐ No (0)
6. In the last 30 days, have you/your child 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/your child had trouble getting along with other people including family and people out the home?
   ☐ Yes (5) ☐ No (0)
8. Do you/your child feel optimistic about the future? ☐ Yes (0) ☐ No (5)

Children Only

9. In the last 30 days, has your child had trouble following the rules at home or school? ☐ Yes (5) ☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)? ☐ Yes (5) ☐ No (0)

Adults Only

11. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
12. In the last 30 days, have you been at risk of losing 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.)

	N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐
Delusions	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐

	N/A	Mild	Moderate	Severe
Hyperactivity/Inattn.	☐	☐	☐	☐
Irritability/Mood Instability	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Hopelessness	☐	☐	☐	☐
Other Psychotic Symptoms	☐	☐	☐	☐

Other (include severity):_____

Have any questions?
Call us at 1.877.644.4613

www.coordinatedcarehealth.com

Member Name _____

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

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	Drug(s) of Choice:_____				

Last Date of substance use:_____

RISK ASSESSMENT

Suicidal:	☐None	☐Ideation	☐Planned	☐Imminent Intent	☐History of self-harming behavior
Homicidal:	☐None	☐Ideation	☐Planned	☐Imminent Intent	☐History of self-harming behavior
Safety Plan in place? (If plan or intent indicated):			☐Yes	☐No	
If prescribed medication, is member compliant?			☐Yes	☐No	

CURRENT MEASUREABLE TREATMENT GOALS

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

Behaviroal Health Outpatient Servies (billed as CPT codes)	FREQUENCY: How Often Seen	INTENSITY: # Units Per Visit	Requested Start Date for this Auth	Anticipated Completion Date of Service
☐ Individual Therapy				
☐ Family Therapy				
☐ Group Therapy				
☐ Interactive Individual Therapy (under age 21 ONLY)				
Meciation Management plus Therapy, same provider.Use if: Healthy Options after exhaustion of 20/12 OR Basic Health Non-Par Providers only.				
IF YOU ARE A NONPARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE AND ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR. OTHER CODE(S) 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

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