**Behavioral Health Outpatient Authorization Request**
Please print clearly – incomplete or illegible forms will delay processing
**FAX COMPLETED FORMS TO: 1-866-877-5229**

**Anthem Blue and Cross Blue Shield Medicaid**

**MEMBER INFORMATION:**

Patient Name _____

Health Plan _____

DOB _____

Medicaid RID # _____

Last Authorization # _____

Impact Plus Member? ☐ Yes ☐ No

**PROVIDER INFORMATION:**

Provider Name _____

Provider Credential ☐ MD ☐ PHD ☐ OTHER (please list)

Group / Agency Name _____

Physical Address _____

Telephone Number _____ Facsimile Number _____

Medicaid / TPI / NPI # _____ Tax ID # _____

Please indicate to whom the authorization should be made
Individual Provider ☐ Yes ☐ No
Group / Facility ☐ Yes ☐ No

**PREVIOUS BH/SA TREATMENT:** ☐ None -or- ☐ OP ☐ MH ☐ SA and/or ☐ IP ☐ MH ☐ SA

List names / dates including hospitalizations if applicable: _____

_____

**Substance Abuse:** ☐ None ☐ By History and/or ☐ Current/Active

**Tobacco Abuse**: ☐ None ☐ By History and/or ☐ Current/Active

Substance(s) used, amount, frequency & last used:

_____

| **CURRENT SYMPTOMS:** | **Severity** (check one) | | |
|---|---|---|---|
| | **Mild** | **Moderate** | **Severe** |
| | | | |
| | | | |
| **PROGRESS SINCE LAST TREATMENT PLAN** | | | |
| | | | |
| | | | |

**TREATMENT GOALS (List Primary Complaint/Problem to be Addressed):**

_____

_____

**List Measurable Treatment Goals/Skills/Activities/Objectives:**

_____

_____

**DISCHARGE GOALS:**

Objectively describe how you will know the patient is ready to discontinue treatment.

_____

_____

**Diagnosis**:

_____

_____

_____

_____

If the Member has a substance use and / or HIV diagnosis, has a consent to release information for these related conditions been obtained?

☐ Yes ☐ No ☐ N/A

**Primary Medical Physician (PCP) Communication:**

Has information been shared with the PCP regarding:

- The initial evaluation & treatment plan? ☐ Yes ☐ No
- This updated evaluation & treatment plan? ☐ Yes ☐ No

PCP Name/Date last notified:

_____

If **NO**, please explain:

_____

**Current Risk/Lethality:**

| | | | | | |
|---|---|---|---|---|---|
| Suicidal* | ☐ 1 NONE | ☐ **2 LOW*** | ☐ **3 MOD*** | ☐ **4 HIGH*** | ☐ **5 EXTREME*** |
| Homicidal* | ☐ 1 NONE | ☐ **2 LOW*** | ☐ **3 MOD*** | ☐ **4 HIGH*** | ☐ **5 EXTREME*** |
| Assault/ Violent Behavior | ☐ 1 NONE | ☐ **2 LOW*** | ☐ **3 MOD*** | ☐ **4 HIGH*** | ☐ **5 EXTREME*** |
| Psychosis | ☐ 1 NONE | ☐ **2 LOW*** | ☐ **3 MOD*** | ☐ **4 HIGH*** | ☐ **5 EXTREME*** |

**Current Risk/Lethality *2-5, Progress/Adherence *1-2** checked, give intervention: _____

_____

***** If **YES** to suicidal/homicidal questions above, Safety Contract Established?

☐ Yes ☐ No

| **Please answer the following questions:** | **YES** | **NO** |
|---|---|---|
| Is Member currently participating in any community based support groups / interventions? | ☐ | ☐ |
| Are the Member's family/supports involved in treatment? If **NO**, please explain: | ☐ | ☐ |
| Coordination of care with other behavioral health providers? | ☐ | ☐ |
| Coordination of care with medical providers? | ☐ | ☐ |
| Is Member currently receiving Medicaid Rehabilitation Option Services? If **YES**, please describe: | ☐ | ☐ |

**MEDICATIONS** (note difficulty with adherence)**:**

_____

_____

_____

_____

***Adherence to treatment**:

| | | | | |
|---|---|---|---|---|
| ☐ **1 NONE*** | ☐ **2 MIN*** | ☐ 3 MOD | ☐ 4 MAX | ☐ 5 MET |

Medical Psychiatric Eval done? (even if PCP providing meds) ☐ Yes ☐ No

Medication given by: ☐ Psychiatrist ☐ PCP ☐ N/A

**REQUESTED SERVICE AUTHORIZATION:**

**Services Requested:** ☐ Individual ☐ Group ☐ Family ☐ Med Management ☐ ECT (Call Medical Management) ☐ Psychosocial Rehabilitation

**Total sessions requested:** _____ **Frequency of visits:** _____ **CPT/HCPCS Codes:** _____

**Estimated # of sessions to complete treatment episode:** _____ **Requested Start Date:** _____

**Provider Signature/ Date:** _____

**Notes:**

**-Psychological/Neuropsychological Testing requests require a separate form**