carelon

Requested Start Date ____/____/____

NOTE: This form cannot be used to request ECT or psychological testing.

Type of Service Requested: ❑ Mental Health ❑ Substance Abuse

Patient Name: _____

Date of Birth: _____Age: _____ ❑ M ❑ F

Address (City/State only): _____

Tel #: _____Patient's Insurance ID#:_____

Patient's Employer/Benefit Plan: _____

Provider Name: _____License: _____

Name of Program/Clinic (if applicable): _____

Carelon Provider ID # (if known): _____Tel #_____

Service Address: _____

City/State/Zip: _____

Is this also your mailing address? ❑ Yes ❑ No If not, please update below signature.

Are you independently licensed to provide services in the State where you are treating this patient? ❑ Yes ❑ No

ID #: _____ *Check Which*: ❑ SSN ❑ Tax ID ❑ NPI

Diagnosis:

Behavioral DX (ICD Code & Description):

1. _____/_____ 2. _____/_____

Medical DX (ICD code & category:

1. _____/_____ 2. _____/_____

Social Elements Impacting DX: 1. _____ 2. _____

Optional Functional Assessment: Tool: _____ Score:_____

Additional Info: _____

Treatment History: (*please select all that apply*)

Previous Treatment in the Past 12 Months, excluding current course of treatment:

Type:❑ Mental Health ❑ Substance Abuse ❑ Both ❑ None ❑ Unknown

❑ Outpatient ❑ Partial/IOP ❑ Inpatient ❑ Residential ❑ Group Home ❑ Other

Outcome: ❑ Unknown ❑ Improved ❑ No Change ❑ Worse

Treatment Compliance (Non-Med): ❑ Unknown ❑ Poor ❑ Fair ❑ Good

Is the individual currently receiving disability benefits ❑ Yes ❑ No

Current Risk Assessment: *(Please select/circle one value for each type of risk*

Key: 0 = none; 1 = mild, ideation only; 2 = moderate, ideation with EITHER plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means; na = not assessed)

Patient's risk to others:	0	1	2	3	na
Patient's risk to self::	0	1	2	3	na

Outpatient Review

Current Impairments: *(Please select/circle one value for each type of impairment)*

Scale: 0=none 1=mild/mildly incapacitating 2=moderate/moderately incapacitating 3=severe or severely incapacitating na=not assessed

- Mood Disturbance (Depression or Mania) 0 1 2 3 na
- Anxiety 0 1 2 3 na
- Psychosis/Hallucinations/Delusions 0 1 2 3 na
- Thinking/Cognition/Memory/Concentration Problems 0 1 2 3 na
- Impulsive/Reckless/Aggressive Behavior 0 1 2 3 na
- Activities of Daily Living Problems 0 1 2 3 na
- Weight Change Associated with a Behavioral Diagnosis 0 1 2 3 na
  Select One: ❑Gain ❑Loss ❑na of _____ lbs. in last three months
  Current weight = _____ lbs. ❑na Height = _____ft. _____ inches ❑na
- Medical/Physical Condition 0 1 2 3 na
- Substance Abuse/Dependence 0 1 2 3 na
  Select all that apply: ❑Alcohol ❑Illegal Drugs ❑Prescription Drugs
- Job/School Performance Problems 0 1 2 3 na
- Social/Relationship/Marital/Family Problems 0 1 2 3 na
- Legal Problems 0 1 2 3 na

Treatment Plan: *Reason for continued treatment (please select primary reason)*

❑ Remains symptomatic ❑ Prepare for discharge within coming month

❑ Maintenance ❑ Facilitate return to work

*Please indicate type(s) of service provided **BY YOU**, and the frequency.*

❑ Medication Management M0064	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	
❑ Indiv. Psychotherapy (30 min) 90832	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	
❑ Indiv. Psychotherapy (45 min) 90834	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	
❑ Family Psychotherapy (45-50 min) 90847	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	
❑ Group Therapy (60-90 min) 90853	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	
❑ Other _____	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	
❑ Other _____	❑Wkly	❑Monthly	❑Qtrly	❑Other _____	

*Please indicate type(s) of service provided **BY OTHERS** (select all that apply):*

❑ Medication Management ❑ Indiv. Psychotherapy ❑ Family Psychotherapy

❑ Group Therapy ❑ Community Program(s) ❑ Self Help Group(s)

Are the Patient's family/supports involved in treatment? ❑ Yes ❑ No

Has Patient been evaluated by a psychiatrist: ❑ Yes ❑ No

Current Psychotropic Medications: Dosage Frequency Usually adherent?

1. ❑ YES ❑ NO
2. ❑ YES ❑ NO
3. ❑ YES ❑ NO

Treating Provider's Signature: _____Date: _____

Updated Mailing Address: _____

City/State/Zip: _____

Providers are expected to endorse their use of Clinical Practice Guidelines based interventions as part of their treatment with this member. This applies to all Behavioral Health conditions and includes additional interventions for Diagnosis Specific conditions /populations as appropriate. This information is required as part of the review process. Please complete both sides of this page as applicable.

The patient's chart reflects that:

1. I am treating this patient according to Carelon treatment guidelines.
   ❑ Y ❑ N ❑ NA

2. I am coordinating this patient's case with other providers as appropriate.
   - Behavioral: ❑ Y ❑ N ❑ NA
   - Medical: ❑ Y ❑ N ❑ NA

3. The treatment plan was developed with the patient and has measurable, time-limited goals. ❑ Y ❑ N ❑ NA

GUIDELINE BASED INTERVENTIONS FOR ALL BEHAVIORAL HEALTH CONDITIONS :

- ❑ Co-occurring medical conditions have been assessed and addressed, if applicable in treatment plan
- ❑ For primary psychiatric disorders, co-occurring substance use conditions have been assessed and addressed, if applicable, in treatment plan
- ❑ For primary substance abuse disorders, co-occurring psychiatric conditions have been assessed and addressed, if applicable, in treatment plan
- ❑ For conditions where Evidence Based Practice guidelines recommend pharmacological treatment, appropriate options have been evaluated and/or prescribed by the member's PCP/Psychiatrist.

- ❑ Treatment process includes one or more evidenced based psychosocial treatment modalities:
  - ❑ Cognitive behavioral therapies including social skills training, destabilization prevention, relapse prevention, standard cognitive therapy
  - ❑ Motivational Enhancement therapy
  - ❑ Illness management skills
  - ❑ Family interventions/ therapy as indicated
  - ❑ Community based self-help organizations and peer support groups

- ❑ Clinical impairment rating and treatment plan reflects either improvement in symptoms within 90 days of treatment onset, or, if not, patient's condition has been re-evaluated and adjustments in treatment plan made accordingly

- ❑ Risk issues have been assessed and addressed in treatment plan and addressed in treatment plan and are continually monitored during treatment.

Patient Name:_____ **ID#**_____
(name and ID are needed to ensure that both pages are for same individual)

DIAGNOSIS SPECIFIC ADDITIONAL GUIDELINE BASED INTERVENTIONS— complete as indicated for the following diagnosis specific conditions/populations:

Alcohol related disorders

- ❑ To promote abstinence and prevent relapse, Pharmacotherapy options have been presented to member including:
  - ❑ Acamprosate (Campral)
  - ❑ Disulfiram (Antabuse)
  - ❑ Oral Naltrexone (ReVia, Depade)
  - ❑ Extended-release injectable naltrexone (Vivitrol)
- ❑ Relapse contingency planning is incorporated in treatment process
- ❑ Aftercare support is incorporated in the treatment process

Child and Adolescent

- ❑ Available ancillary and/or supportive services have been evaluated and are utilized as needed

Cognitive disorders

- ❑ Caregivers are encouraged to seek support, if applicable, including education programs, respite care and support groups
- ❑ The use of pharmacologic treatment for cognitive impairment has been discussed with the member or their proxy
- ❑ Medical explanations have been considered/ruled out in reaching this diagnosis

Eating Disorder:

- ❑ Treatment plan includes monitoring and documentation of target weight and rate of progress.
- ❑ Patient is receiving nutritional counseling by a trained provider.

Psychotic Disorders:

- ❑ The treatment plan continues to reinforce adherence with psychopharmacological interventions.