

**Please note: Out-of-network providers require a prior authorization for all services. If you have a question about services that require prior authorization, please contact AmeriHealth Caritas Delaware behavioral health Utilization Management (BH UM) at 1-855-301-5512. Incomplete or illegible forms will delay processing.**

Electroconvulsive therapy (ECT), TMS, and vagus nerve stimulation (VNS) are to be requested using the forms specific to those services.

MEMBER INFORMATION	
Member name:	
Medicaid or other health plan number:	
Date of birth:	Last authorization number (if applicable):
PROVIDER INFORMATION	
Provider name:	
<input type="checkbox"/> In network <input type="checkbox"/> Out of network <input type="checkbox"/> In credentialing process	
Group or agency name:	
Provider credential: <input type="checkbox"/> M.D. <input type="checkbox"/> Ph.D. <input type="checkbox"/> LMHP <input type="checkbox"/> LAC <input type="checkbox"/> NP <input type="checkbox"/> Other, please specify:	
Physical address:	
Phone number:	Fax number:
Medicaid/provider/NPI number:	Contact name:
If out of network, please complete the fields below: (Utilization Management will contact the provider directly before giving an authorization.)	
1. Specialty of provider to meet the needs of the member:	
2. Continuity of care concerns:	
3. Accessibility and availability of provider:	
4. Clinical rationale:	
Previous or current BH/SA treatment: <input type="checkbox"/> None <b>or</b> <input type="checkbox"/> MH/SUD OPT <input type="checkbox"/> MH/SUD IOP <input type="checkbox"/> MH/SUD PHP <input type="checkbox"/> MH IP <input type="checkbox"/> SUD residential <input type="checkbox"/> Other (provide specifics):	
Substance abuse: <input type="checkbox"/> None <input type="checkbox"/> By history or <input type="checkbox"/> Current or active Tobacco abuse: <input type="checkbox"/> None <input type="checkbox"/> By history or <input type="checkbox"/> Current or active Substance(s) used, amount, frequency, and last used:	
Previous or current waiver services: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give specifics:	
DSM diagnosis:	
Primary diagnosis:	Secondary diagnosis:                      Medical diagnosis:
Primary care physician (PCP) and other communication: Has information been shared with the PMP/other providers regarding:	
1. The initial evaluation and treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. The updated evaluation and treatment plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other behavioral health provider names and last notified:	
PCP name:	Date last notified:
If no, please explain:	

# Behavioral Health Outpatient Treatment Request Form (OTR)



## PROVIDER INFORMATION

Is the member's family and support system involved in treatment planning and treatment?  Yes  No

If no, explain:

Was the member given a choice in their behavioral health or substance abuse provider?  Yes  No

If no, explain:

## CURRENT RISK AND LETHALITY

Suicidal	<input type="checkbox"/> 1 None	<input type="checkbox"/> 2 Low	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 High	<input type="checkbox"/> 5 Extreme	Medications: Is the member prescribed medications?
Homicidal	<input type="checkbox"/> 1 None	<input type="checkbox"/> 2 Low	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 High	<input type="checkbox"/> 5 Extreme	<input type="checkbox"/> Yes <input type="checkbox"/> No Prescribing physician(s) name(s):
Assault or violence	<input type="checkbox"/> 1 None	<input type="checkbox"/> 2 Low	<input type="checkbox"/> 3 Moderate	<input type="checkbox"/> 4 High	<input type="checkbox"/> 5 Extreme	Is the member compliant with medications? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list medications and dosages:

Treatment request:  Individual  Group  Family  Medical Management

Other (please specify):

Presenting problem (list primary complaint or problem to be addressed):

Treatment plan and goals (list measurable treatment goals):

Overall progress toward goals:  1 None or minimal  2 Moderate  3 Met

Compliance with treatment:  1 None or minimal  2 Moderate  3 Met

Number of sessions requested:

Frequency of visits:

CPT/HCPC codes:

Start date:

Estimated end date:

Provider or requestor signature:

Date: