

BCN Behavioral Health Outpatient Treatment Authorization Form

Fax completed form to:
734-332-2519

Member name:		Member number:		Date of birth:	
Clinician name/degree:		Clinic:		Clinic/provider phone:	
Clinic/provider fax:		Clinic/provider address:			
Treatment history:	Date first seen	Date last seen	Total # sessions to date	Total # sessions last 12 months	
	This treatment episode				
	This therapist		N/A – same as above		
	Lifetime	Total time in treatment (approximate):			
Prior treatment type: MH: <input type="checkbox"/> IP <input type="checkbox"/> PHP <input type="checkbox"/> IOP <input type="checkbox"/> OP SA: <input type="checkbox"/> IP <input type="checkbox"/> PHP <input type="checkbox"/> IOP <input type="checkbox"/> OP			Substance abuse: Member screened? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No problem indicated		
Current diagnosis codes:		Axis I: _____		Axis II: _____	
		Axis IV: _____		Axis III: _____	
		Axis V: Current GAF: _____ / Highest GAF in last 12 months: _____			
Current symptoms (that support diagnosis) and functional impairment: (Note: Symptoms must match diagnosis and must be of at least moderate severity.)					
Current treatment modality:					
1. Psychotherapy: <input type="checkbox"/> None <input type="checkbox"/> CBT <input type="checkbox"/> DBT <input type="checkbox"/> IPT <input type="checkbox"/> Brief dynamic <input type="checkbox"/> Exposure and response prevention <input type="checkbox"/> Supportive					
<input type="checkbox"/> Other _____					
2. Medications: <input type="checkbox"/> None <input type="checkbox"/> Acute phase <input type="checkbox"/> Continuation phase <input type="checkbox"/> Maintenance / Is member adhering to medications as prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
List medications / any changes since last review: _____					
Medications prescribed by:		<input type="checkbox"/> PCP (name) _____			
		<input type="checkbox"/> Psychiatrist / this clinic (name) _____			
		<input type="checkbox"/> Psychiatrist / other clinic (name) _____			
		<input type="checkbox"/> Other (name) _____			

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Goals:	Objective measures used:	Outcome criteria: (specific, observable, measurable)	Progress toward goal: (since last treatment plan review)
Example: "Remission of depressive symptoms"	Example: "PHQ-9"	Example: "Score <5 for 2 consecutive mos."	Example: "Score = 7 and decreasing"
1.	1.	1.	1.
2.	2.	2.	2.
3.	3.	3.	3.
4.	4.	4.	4.
5.	5.	5.	5.
6.	6.	6.	6.

Treatment adherence:

Is member following all treatment recommendations? Yes No If no, explain: _____

Is member attending treatment regularly? Yes No / Is member completing homework assignments? Yes No Not applicable

<p>How is member being motivated toward independence / compliance with tx?</p>	<p>Estimated # additional sessions to complete tx: _____</p>
	<p>Anticipated discharge date: _____</p>

Provider signature: _____ **Date:** _____ **Provider NPI:** _____ **Provider Tax ID:** _____

FOR BCN use only:
 Additional visits approved _____ Year-to-date sessions _____ Authorization no. _____ Date: _____ Initials _____

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Instructions / definitions / examples

- **TREATMENT HISTORY.** This should provide a summary of the treatment the member has received for the most recent episode as well as an indication of the member's psychiatric treatment over the course of the member's lifetime.
- **PRIOR TREATMENT TYPE.** Please mark a box for each level of care that the member has had prior to this current episode of care. IP = inpatient (mental health hospitalization, substance abuse detox or residential); PHP = partial hospitalization program (5-6 days/wk, 6-8 hrs/day); IOP = intensive outpatient program (3 days/wk, 3 hrs/day); OP = standard outpatient therapy (individual, family, group).
- **SUBSTANCE ABUSE.** Please mark the appropriate box at each review. Each member should be screened for substance abuse at the initial evaluation and again as indicated by your clinical judgment.
- **CURRENT SYMPTOMS/FUNCTIONAL IMPAIRMENT.** This should reflect the member's CURRENT status. If this is the FIRST treatment plan review, you may choose to list the symptoms/impairment that presented initially, and then the current level of impairment. For any subsequent reviews, please list only the symptoms/impairment since your last treatment plan. Examples: "Panic attacks 3x/week; avoids social interaction as result." "Intermittent passive SI on daily basis." "Difficulty functioning in the school setting – noncompliance with teacher requests, disruptive in class, failure to complete assignments." "Continued cravings for alcohol; attending AA weekly, but no sponsor; working on ID of relapse prevention plan."
- **CURRENT TREATMENT MODALITY.** Indicate the current treatment modality, including (but not limited to): CBT (cognitive behavioral therapy), DBT (dialectical behavioral therapy), IPT (interpersonal therapy).
- **MEDICATIONS.** If the member is on psychotropic medication, it is understood that for best clinical practices the therapist will have collaborative contact with the prescribing physician. Please document psychotropic medications in this area, as well as the name(s) of the physician(s) prescribing the medication(s).
- **GOALS.** Describe what the therapist and the member hope to achieve via therapy. Examples: "Decrease in panic attacks; able to manage anxiety more effectively." "Abstinence from alcohol/drug use x 3 months."
- **HOW IS MEMBER BEING MOTIVATED TOWARD INDEPENDENCE / COMPLIANCE WITH TX?** Examples include setting independence from therapy as a stated goal early in treatment, establishing an expected discharge date at the onset of treatment, and tapering the frequency of sessions as treatment progresses.
- **ESTIMATED # ADDITIONAL SESSIONS TO COMPLETE TX / ANTICIPATED DISCHARGE DATE:** Based on your clinical assessment and the status of treatment, please identify the TOTAL number of ADDITIONAL sessions that you will need to COMPLETE the episode of treatment and the anticipated discharge date.
- The provider should **sign and date** the form at the bottom of the page before submitting for review.

When you have completed this form, please FAX it to 734-332-2519.

Sessions are authorized based on the clinical symptoms presented and are limited by benefit availability and medical necessity.