

Patient Name: _____	Patient ID: _____	DOB: _____
Provider Name: _____	Provider NPI: _____	
Provider Phone #: _____	Provider Fax #: _____	
Physical/Service Address: _____		
Requested Start Date of Authorization: _____		

I. Diagnosis: Use DSM-IV; Include all Axes

Axis I _____ Functional Impairments: Job/School Relationships/Family

Axis II (Personality) _____ Disability Other _____

Axis III (Medical conditions) _____

Axis IV (Stressors) _____

Axis V (GAF) Current _____ Highest in the last 12 months _____

II. Current Risk Factors: Check all that apply and explain in Presenting Symptoms section

Suicidal/Homicidal Ideation: (None) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 (Severe) Safety Plan

Substance Abuse: None Remission Unstable Remission Abuse Under Evaluation

III. Treatment Information – Current Episode

First Date of Service: _____ Number of Sessions to date: _____

Number of Sessions Requested at this time: _____

Frequency to date: _____ Frequency Requested: _____

Modality to date: 90806 # ___ 90807 # ___ 90846 # ___ 90847 # ___ 90853 # ___ 90862 # ___

Modality requested: 90806 # ___ 90807 # ___ 90846 # ___ 90847 # ___ 90853 # ___ 90862 # ___

Type of plan: Short term focused Long term care Chronic care

Orientation: Cognitive/behavioral Psychodynamic Supportive/problem Solving Other _____

Identify referrals made (adjunctive therapy, community resources): _____

Have you coordinated care with PCP? Yes No With other providers? Yes No

IV. Medications, prescribed by: PCP PMHNP/ARNP Psychiatrist

Previous (dosage & length of time on medication) _____

Current (dosage & length of time on medication) _____

Reason for Treatment/Presenting Symptoms (specify functional impairments):

Relevant History (personal resources, mental health treatment history, relevant new information):

Treatment Goals (behaviorally defined):	Progress made toward each goal:

Termination Criteria (observable, measurable, and related to symptoms):

Estimated Number of Sessions to Termination of Current Episode of Treatment: _____

Signature: _____ **Licensure:** _____ **Date:** _____

- Fax the completed treatment plan to 1 (888) 496-1540
- To verify benefits and eligibility, please call the number on the back of the member’s card
- For treatment plan and authorization questions only, please call 1 (800) 787-5757