Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date _____

Carrier or Appropriate Recipient:

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH ___ / ___ / ___

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE

Date Patient First Seen For This Episode Of Treatment __/__/____

Level of care being requested: Please specify benefit type:

□ Mental Health □ Substance Use Disorder □ Outpatient □ Intensive Outpatient Program □ Partial Hospitalization Program □ Acute IP □ IP Rehab □ Acute IP Detox □ Residential □ ECT □ rTMS □ Applied Behavior Analysis (ABA) □ Psychological Testing □ BioFeedback □ Telehealth □ Other _____

Primary Dx Code: _____ **Secondary Dx Code(s):** _____

Current Treatment Modalities: (check all that apply)

Psychotherapy: □ Behavioral □ CBT □ DBT □ Exposure □ Supportive Therapy □ Problem Focused □ Interpersonal □ Psychodynamic □ EMDR □ Group □ Couples □ Family □ Other_____

□ **Medical Evaluation and Management**

Type of Medications(if not applicable, no response is required):

□ Antipsychotic □ Anxiolytic □ Antidepressant □ Stimulant □ Injectables □ Hypnotic □ Non-psychotropic □ Mood Stabilizer □ Other _____

Current Symptoms and Functional Impairments: Rate the patient's current status on these symptoms/functional impairments, if applicable.

	Current Ideation	Current Plan	Prior Attempt	None
Suicidal	□	□	□	□
Homicidal	□	□	□	□

Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	□	□	□	□
Substance Use Problems	□	□	□	□
Depression	□	□	□	□
Agitated/aggressive Behavior	□	□	□	□
Mood Instability	□	□	□	□
Psychosis	□	□	□	□
Anxiety	□	□	□	□
Cognitive Impairment	□	□	□	□
Eating Disorder Symptoms	□	□	□	□
Social/ Familial/School/WorkProblems	□	□	□	□
ADL Problems	□	□	□	□

If requesting additional outpatient care for a patient, why does the patient require further outpatient care: □ Maintenance treatment for a chronic condition □ Consolidate treatment gains □ Continued impairment in functioning □ Significant regression □ New symptoms and/or impairments □ Supportive treatment due to other treatment plan changes □ complex psychiatric and medical co-morbidity □ Complex Psychiatric and Substance abuse Co-morbidity

□ other_____

Signature of Practitioner:_____ Date:_____/_____/_____

My signature attests that I have a current valid license in the state to provide the requested services.

***Complete the following if the request is for ECT or rTMS*:** Provide clinical rationale including medical suitability and history of failed treatments:

Requested Revenue/HCPC/CPT Code(s)_____ Number of Units for each _____

Complete the following for Applied Behavior Analysis (ABA) Requests(if the carrier classifies ABA as a mental health benefit):

Supervising BCBA Name_____ Has Autism Spectrum Disorder been validated by MD/DO or Psychologist? Yes No

For initial requests, what are specific ABA treatment goals for the patient?

1. _____
2. _____
3. _____

Date of Evaluation by MD/DO: _____

For continuing requests, assessment of functioning (observed via FBA, ABLLS, VB-MAPP, etc.) related to ASD including progress over the last year:

For continuing requests what are the treatment goals and targeted behaviors, indicating new or continued, with documentation of progress and child's response to treatment:

1. _____
2. _____
3. _____

Requested Revenue/HCPC/CPT Code(s)_____ Number of Units for each _____

Complete the following if the request is for Psychological Testing:

Symptoms/Impairment related to need for testing:

☐ Acute change in functioning from the individual's previous level
☐ Peculiar behaviors and/or thought process
☐ Symptoms of psychosis
☐ Attention problems
☐ Development delay
☐ Learning difficulties
☐ Emotional problems
☐ Relationship issues
☐ Other:_____

Personality problems
☐ School problems
☐ Family issues
☐ Cognitive impairment
☐ Mood Related Issues
☐ Neurological difficulties
☐ Physical/medical signs

Purpose of Psychological Testing:

☐ Differential diagnostic clarification
☐ Help formulate/reformulate effective treatment plan.
☐ Therapeutic response is significantly different from that expected based on the treatment plan.
☐ Evaluation of functional ability to participate in health care treatment.
☐ Other: (describe) _____

Substance use in last 30 days: ☐ Yes ☐ No Diagnostic Assessment Completed: ☐ Yes Date_____/_____/_____☐ No
Patient substance free for last ten days ☐ Yes ☐ No
Has the patient had known prior testing of this type within the past 12 months? ☐ Yes ☐ No
If so, why necessary now? ☐ Unexpected change in symptoms ☐ Evaluate response to treatment ☐ Assess functioning ☐ Other
Names and Number of Hours of each requested test_____

If appropriate, complete this section: Reason(s) why assessment will require more time relative to test standardization samples?

☐ Depressed mood	☐ Vegetative Symptom	☐ Processing speed	☐ Performance Anxiety	☐ Expressive/Receptive Communication Difficulties
☐ Low frustration tolerance	☐ Suspected or Confirmed grapho-motor deficits	☐ Physical Symptoms or Conditions such as: _____ _____	☐ Other:_____ _____ _____	

Requested Revenue/HCPC/CPT Code(s)_____ Number of Units for each _____

Complete the following if the request is for Biofeedback:

Requested Revenue/HCPC/CPT Code(s)_____ Number of Units for each _____

Complete the following if the request is for Telehealth:

Requested Revenue/HCPC/CPT Code(s)_____ Number of Units for each _____

Complete for Higher Level of Care Requests (e.g. inpatient, residential, intensive outpatient and partial hospitalization):

Primary reason for request or admission: (check one) □ Self/Other Lethality Issues □ Violent, unpredictable/uncontrolled behavior
□ Safety issues □ Eating Disorder □ Detox/withdrawal symptoms □ Substance Use □Psychosis □ Mania □ Depression
□ Other _____

Why does this patient require this higher level of care at this time? (Please provide frequency, intensity, duration of impairing behaviors and symptoms): _____

Medication adjustments (medication name and dose) during level of care: _____

Barriers to Compliance or Adherence: _____

Prior Treatment in past 6 months:
□ Mental Health □ Substance Use Disorder □ Inpatient Residential □ Partial Intensive Outpatient □ Outpatient
Relevant Medical issues (if any): _____

Support System/Home Environment: _____

Treatment Plan (include objectives, goals and interventions): _____

If Concurrent Review—What progress has been made since the last review _____

Why does member continue to need level of care _____

Discharge Plan (including anticipated discharge date) _____

Complete the following if the request is Substance Use related: rate the patient's current severity/risk and current need for treatment services intensity on these Dimensions:

	Low	Medium	High
1. Acute intoxication and/or withdrawal potential			
2. Biomedical conditions and complications			
3. Emotional, behavioral, or cognitive conditions and complications			
4. Readiness to charge			
5. Relapse, continued use, or continued problem potential			
6. Recovery/living environment			

Add details or explanation needed for each dimension

Complete the following if substance use is present for higher level of care requests:

Type of substance use disorder _____

Onset: Recent Past 12 Months More than 12 months ago

Frequency: Daily Few Times Per Week Few Times Per Month Binge Pattern

Last Used: Past Week Past Month Past 3 Months Past Year More than one year ago

Consequences of relapse: Medical Social Housing Work/School Legal Other_____Urine Drug Screen: Yes No Vital Signs:_____Current Withdrawal Score: (CIWA_____COWS_____) or Symptoms (check if not applicable) _____

History of: Seizures DT's Blackouts Other Not Applicable

Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:

Height:_____Weight:_____% of NBW_____

Highest weight_____Lowest weight_____Weight change over time (e.g. lbs lost in 1 month) _____

If purging, type and frequency_____Potassium_____Sodium_____Vital signs _____

Abnormal EKG_____ Medical Evaluation □ Yes □ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues: _____

Please include any current medical/physiological pathologic manifestations: _____

_____

_____