of Tennessee

Mental Health Outpatient Request Form

Please check line of business for this form:

☐ BlueAdvantage (PPO)SM ☐ BlueCare Plus (HMO SNP)SM ☐ CoverKids
☐ BlueCareSM ☐ TennCare*Select*

Level of care requesting (case type): (please check the appropriate level of care).

- ☐ Partial hospitalization programming (PHP):
  - ☐ PHP - Mental health primary:
  - ☐ PHP - Substance abuse primary:
- ☐ Intensive outpatient programming (IOP):
  - ☐ IOP - Mental health primary:
  - ☐ IOP - Substance abuse primary:
- ☐ Comprehensive child and family therapy (CCFT):
- ☐ Continuous treatment team (CTT):
- ☐ Psychological testing (see other specific form):
- ☐ TMS (transcranial magnectic stimulation):
- ☐ Program of assertive community treatment (PACT):
- ☐ Outpatient routine psychiatry (no precert required if in network)
- ☐ Outpatient routine therapy (no precert required if in network)
- ☐ Applied behavior analysis (ABA):
- ☐ Routine supported housing:
- ☐ Enhanced supported housing:
- ☐ Medically fragile supported housing:
- ☐ BH respite:
- ☐ Electro convulsive therapy (ECT):

Member number: ______________________________

Member name:______________________________

Member date of birth: ______________________________

Member contact number: ______________________________

Date request sent: ______________________________

**Initial: ☐ Yes or ☐ No

**Concurrent: ☐ Yes or ☐ No

**If concurrent, please list auth number and fill out remainder of this section and then skip to concurrent review and treatment/discharge planning section towards bottom of form.

**Auth number: ____________________

Provider name: ____________________

Provider phone: ____________________

Provider fax: ____________________

Place of service: on campus outpatient hospital, off campus outpatient hospital, office

Requesting clinician: ____________________

Clinician provider ID #: ____________________

Clinician NPI #: ____________________

Clinician address: ____________________

Treating clinician: ____________________

Clinician provider ID #: ____________________

Clinician NPI #: ____________________

Clinician address: ____________________

Requested facility: ____________________

Facility provider ID #: ____________________

Facility NPI #: ____________________

Facility address: ____________________

Psychiatric ICD-10 diagnosis codes:

1) ____________________

2) ____________________

3) ____________________

4) ____________________

5) ____________________

Medical ICD-10 diagnosis codes:

1) ____________________

2) ____________________

3) ____________________

4) ____________________

5) ____________________

Requested start date of service:__________________________________

Units or number of days requesting: ________________________________

Clinical information section

(For initial review, please see other applicable sections below and fill out all that apply.)

Describe in detail the patient's current condition to include…(thorough mental status, behavioral symptoms)

Suicidal ideation? (plans/means/intent) ☐ Yes or ☐ No

Homicidal ideation? (plans/means/intent) ☐ Yes or ☐ No

Psychosis? ☐ Yes or ☐ No

Other symptoms/concerns:

Is there duty to warn? ☐ Yes or ☐ No

Describe any history of attempts (suicidal attempts, homicidal attempts or overall aggression towards others and/or property).

Precipitant:

Treatment history:

What is patient's baseline?

Why can the member not be treated in a lower level of care at this time?

Medications	Dose	Frequency	Dates	Outcome

Medication adherence? Barriers to adherence?

Urinary Drug Screen (UDS) and/or Blood Alcohol (BAL) results:

Fill out this section only if patient is under the age of 18.

Who has custody of patient?

Is there any current CPS/DCS involvementt? ☐ Yes or ☐ No

Do any current symptoms/behaviors occur in school setting? ☐ Yes or ☐ No

Is the school involved in current treatment plan? ☐ Yes or ☐ No

Is the member involved with special education? ☐ Yes or ☐ No

Fill out this section only if patient has substance abuse issues.

note above referenced UDS and BAL

Drugs of choice	Amount of use	Frequency of use	Age of first use	Date of last use	Method of adminstration

Longest period of sobriety: ___________________________

Vital signs: *Blood pressure: __________ *Heart rate: __________ *Temperature: __________

Is there history of seizures, DT's (delerium tremens) or blackouts? ☐ Yes or ☐ No

Current withdrawal symptoms:

Psychological and/or legal consequences of substance use:

Substance abuse treatment history:

Support group involvement:

Patient's triggers:

Fill out this section only if patient has eating disorder issues.

Patient height: ___________________________

Patient weight: ___________________________

% Ideal body weight (IBW): ___________________________

Current BMI: ___________________________

Orthostatic blood pressure: ___________________________

Standing: ___________________________

Sitting: ___________________________

Pulse rate: ___________________________

EKG, electrolytes, and other lab information:

Goal weight/BMI ___________________________

Last known episode of binging/purging/witholding:

Triggers for binging/purging/witholding:

Precipitant(s):

Fill out this section only if patient needs sexual offender related services.

Presenting problem:

What is current involvement with legal system and/or DCS?

When was the last time these behaviors occurred?

In what setting do these behaviors occur?

Is the school setting involved in current treatment plan? ☐ Yes or ☐ No

Has a psychosexual assessment been completed prior to this request? ☐ Yes or ☐ No

If yes, please attach said assessment.

Fill out this section for concurrent review only, then skip down to treatment and discharge planning section.

What progress has been made since the last review in regards to symptoms, behaviors, diagnosis, etc?

Is there ongoing suicidal/homicidal ideations or psychosis? ☐ Yes or ☐ No

Medication changes:

If no progress, how will the treatment plan be changed?

Family involvement (phone, education, family sessions, visitations), please list details:

Treatment and Discharge Planning Section

List the goals necessary and attainable for the patient/family within requested treatment setting:

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

5) ______________________________

What is the anticipated treatment plan for the patient in the requested level of care?

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

5) ______________________________

Are there any limitations for family participation in treatment (transportation, legal, etc.)? (If yes, please provide details.)

1) ______________________________

2) ______________________________

3) ______________________________

Discharge plan:

Anticipated barriers to discharge:

Primary care physician name and efforts to coordinate care:

Signature of ordering clinician with credentials (required in order to process):

____

Date of signature:______________________________

Fax pre-certification numbers:

BlueAdvantage: 1-888-535-5243

BlueCare Plus: 1-866-325-6698

Bluecare/TennCare*Select*: 1-800-292-5311

CoverKids: 1-800-851-2491

Customer service numbers:

BlueAdvantage: 1-800-841-7434

BlueCare Plus: 1-800-299-1407

BlueCare: 1-800-468-9736

TennCare*Select*: 1-800-276-1978

CoverKids: 1-800-924-7141

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BlueCare Behavioral Fax Form-
Mental Health Outpatient