Outpatient Treatment Request (OTR)

Non-Participating Providers

SUBMIT TO:Cenpatico
12515-8 Research Blvd, Suite 400
Austin, Texas 78759
FAX 866.694.3649

DATE

MEMBER INFORMATION

NAME

DATE OF BIRTH

MEMBER ID #

PROVIDER INFORMATION

PROVIDER NAME

PROVIDER/AGENCY TAX ID #

PROVIDER/AGENCY NPI SUB PROVIDER #

PHONE FAX

DSM-IV TR DIAGNOSIS

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V

Has contact occured with PCP? ☐ YES ☐ NO

DATE FIRST SEEN BY PROVIDER/AGENCY

DATE LAST SEENBY PROVIDER/AGENCY

FUNCTIONAL OUTCOMES (To be completed by provider during a face-to-face interview with member or guardian. Questions are in reference to the patient.)

1. In the last 30 days, have you/your child had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you/your child had problems with fears and anxiety? ☐ Yes (5) ☐ No (0)
3. Do you/your child currently take mental health medicines as prescribed by your doctor? ☐ Yes (0) ☐ No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you or your child? ☐ Yes (5) ☐ No (0)
5. In the last 30 days, have you/your child gotten in trouble with the law? ☐ Yes (5) ☐ No (0)
6. In the last 30 days, have you/your child actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
   ☐ Yes (0) ☐ No (5)
7. In the last 30 days, have you/your child had trouble getting along with other people including family and people outside the home?
   ☐ Yes (5) ☐ No (0)
8. Do you/your child feel optimistic about the future? ☐ Yes (0) ☐ No (5)

Children Only:

9. In the last 30 days, has your child had trouble following rules at home or school? ☐ Yes (5) ☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)? ☐ Yes (5) ☐ No (0)

Adults Only:

11. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
12. In the last 30 days, have you been at risk of losing your living situation? ☐ Yes (5) ☐ No (0)

THERAPEUTIC APPROACH/EVIDENCE BASED TREATMENT USED

LEVEL OF IMPROVEMENT TO DATE

☐ Minor ☐ Moderate ☐ Major ☐ No progress to date ☐ Maintenance treatment of chronic condition

BARRIERS TO DISCHARGE

SYMPTOMS (If present, check degree to which it impacts daily functioning.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐	Hyperactivity/Inattn.	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Irritability/Mood Instability	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Hopelessness	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐	Other (include severity):				

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (If present, check degree to which it impacts daily functioning.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Work/School	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	Drug(s) of Choice:				

Last Date of Substance use: _____

RISK ASSESSMENT

Suicidal: ☐ None ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ History of self-harming behavior

Homicidal: ☐ None ☐ Ideation ☐ Planned ☐ Imminent Intent ☐ History of harm to others

Safety Plan in place? (if plan or intent indicated): ☐ Yes ☐ No

If prescribed medication, is member compliant? ☐ Yes ☐ No

Member Name

CURRENT MEASUREABLE TREATMENT GOALS

Requested Authorization (Please check off appropriate box to indicate modifier, if applicable)

SERVICE	DATE SERVICE STARTED	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # UNITS PER VISIT	REQUESTED START DATE FOR THIS AUTH	ANTICIPATED COMPLETION DATE OF SERVICE
Individual Psychotherapy					
☐ 90832					
☐ 90834					
☐ 90837					
Group Psychotherapy					
☐ 90853					

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Additional information?

PROVIDER NAME PROVIDER SIGNATURE DATE

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

SUBMIT TO: **Utilization Management Department** 12515-8 Research Blvd, Ste 400, Austin, TX 78759 PHONE 877-658-0305 FAX 866.694.3649