

# Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date \_\_\_\_\_

Carrier or Appropriate Recipient:

<p><b>PATIENT INFORMATION</b></p> <p>PATIENT'S FIRST NAME      PATIENT'S DATE OF BIRTH</p> <p>_____      ____ / ____ / ____</p> <p>MEMBERSHIP NUMBER</p> <p>_____</p> <p>AUTHORIZATION NUMBER (If Applicable)</p> <p>_____</p>	<p><b>PRACTITIONER INFORMATION</b></p> <p>PRACTITIONER ID# or TAX ID      PHONE NUMBER</p> <p>_____      _____</p> <p>PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE</p> <p>_____</p> <p>_____</p> <p>Date Patient First Seen For This Episode Of Treatment __/__/__</p>
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**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitated/aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social/ Familial/School/WorkProblems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADL Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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:**

- |   |  |
|---|--|
| <input type="checkbox"/> Acute change in functioning from the individual's previous level | <input type="checkbox"/> Personality problems      |
| <input type="checkbox"/> Peculiar behaviors and/or thought process                        | <input type="checkbox"/> School problems           |
| <input type="checkbox"/> Symptoms of psychosis  | <input type="checkbox"/> Family issues             |
| <input type="checkbox"/> Attention problems   | <input type="checkbox"/> Cognitive impairment      |
| <input type="checkbox"/> Development delay  | <input type="checkbox"/> Mood Related Issues       |
| <input type="checkbox"/> Learning difficulties  | <input type="checkbox"/> Neurological difficulties |
| <input type="checkbox"/> Emotional problems   | <input type="checkbox"/> Physical/medical signs    |
| <input type="checkbox"/> Relationship issues  |  |
| <input type="checkbox"/> Other: _____   |  |

**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?

<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Vegetative Symptom	<input type="checkbox"/> Processing speed	<input type="checkbox"/> Performance Anxiety	<input type="checkbox"/> Expressive/ Receptive Communication Difficulties
<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Suspected or Confirmed grapho-motor deficits	<input type="checkbox"/> Physical Symptoms or Conditions such as: _____ _____	<input type="checkbox"/> 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 \_\_\_\_\_

Patient Membership Number \_\_\_\_\_

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**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 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: \_\_\_\_\_  
\_\_\_\_\_