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 _____

Patient Membership Number_____

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 states on these conditions, if applicable.

	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 change			
5. Relapse, continued use, or continued problem potential			
6. Recovery/living environment			

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: _____