

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date _____

Carrier or Appropriate Recipient:

<p>PATIENT INFORMATION</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>PRACTITIONER INFORMATION</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: _____

