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:

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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:

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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 ___________________________

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: ____

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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: ____

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____

Treatment Plan (include objectives, goals and interventions): ____

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If Concurrent Review—What progress has been made since the last review ____

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____

Why does member continue to need level of care ____

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____

Discharge Plan (including anticipated discharge date) ____

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Complete the following if the request is Substance Use related: rate the patient's current severity/risk and current need for treatment services intensity on these Dimensions:

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

Add details or explanation needed for each dimension

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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: ____

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