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Outpatient Mental Health Treatment Plan

Please complete this entire form and fax to the attention of Administrative Assistant, Behavioral Health, at (608) 661-6706

Clinic:		Tax ID:	
Clinician Name, Credentials:		Clinic Phone:	Fax No.:
Address:		Patient Name:	
City:		Subscriber ID:	
State:	Zip:	Patient DOB:	

First date of service: _____

Authorization requested from date: _____ **Anticipated closure date:** _____

DSM IV Diagnosis—Axis I through V:

Axis I: _____ **Code(s):** _____

Axis II: _____ **Code(s):** _____

Axis III: _____

Axis IV (specify): _____

Axis V: Current GAF: _____ Highest GAF past year: _____

Current Psychiatric Status *(mark where applicable):*

	Initial date: _____			Current date: _____		
Symptoms/Problems	**Mild**	**Moderate**	**Severe**	**Mild**	**Moderate**	**Severe**
Depressed mood	❑	❑	❑	❑	❑	❑
Obsessions/compulsions	❑	❑	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑	❑	❑
Impulsiveness	❑	❑	❑	❑	❑	❑
Somatic complaints	❑	❑	❑	❑	❑	❑
Poor judgment	❑	❑	❑	❑	❑	❑
Sexual issues	❑	❑	❑	❑	❑	❑
Impaired concentration	❑	❑	❑	❑	❑	❑
Appetite disturbance	❑	❑	❑	❑	❑	❑
Irritability	❑	❑	❑	❑	❑	❑
Hyperactivity	❑	❑	❑	❑	❑	❑
Sleep disturbance	❑	❑	❑	❑	❑	❑
Delusions	❑	❑	❑	❑	❑	❑
Paranoia	❑	❑	❑	❑	❑	❑
Panic attacks	❑	❑	❑	❑	❑	❑
Hallucinations	❑	❑	❑	❑	❑	❑
Phobias	❑	❑	❑	❑	❑	❑
Impaired memory	❑	❑	❑	❑	❑	❑
Alcohol abuse	❑	❑	❑	❑	❑	❑
Opiate abuse	❑	❑	❑	❑	❑	❑
Prescription medicine abuse	❑	❑	❑	❑	❑	❑
Polysubstance abuse	❑	❑	❑	❑	❑	❑

Over →

Current Psychiatric Status—Risk Assessment *(mark where applicable):*

	Initial date:			Current date:							
	Mild	**Moderate**	**Severe**	**Mild**	**Moderate**	**Severe**	**Thought**	**Plan**	**Means**	**Method**	**Gesture**
Suicidality	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Homicidality	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
Violence	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Current Medications *(Please list name, dose, date started, and compliance.):*

_____

_____

Current medications are prescribed by: _____

❑ **Psychiatrist** ❑ **Primary care provider** ❑ **Other:** _____

Narrative Summary *(Please note current level of functioning in life domains, progress made, and symptoms still in need of improvement.):*

_____

_____

_____

_____

_____

_____

_____

_____

(If additional space is needed, please attach your notes to this form.)

Treatment Approach(es):

❑ Cognitive/behavioral ❑ DBT ❑ Solution-focused ❑ Psychoanalytical ❑ Interpersonal ❑ Other: _____

Covered Treatment(s): Only the following procedure codes will be considered for preauthorization. Extended individual psychotherapy (beyond 50 minutes, such as 90808) requires a separate preauthorization.

		Total # of Sessions							**Frequency of Sessions**			
A. Medication management:												
		2	**4**	**6**	**8**	**10**	**12**	**Other**	**Weekly**	**1 in 2 wks (biweekly)**	**Monthly**	**Other**
Medication mgnt.:	**90862 and/or 90805 (please circle one)**	❑	❑	❑	❑	❑	❑	_____	❑	❑	❑	_____
B. Psychotherapy with/without medication management:												
		2	**4**	**6**	**8**	**10**	**12**	**Other**	**Weekly**	**1 in 2 wks (biweekly)**	**Monthly**	**Other**
Individual or family	**90804, 90806, 90847**	❑	❑	❑	❑	❑	❑	_____	❑	❑	❑	_____
Group	**90853**	❑	❑	❑	❑	❑	❑	_____	❑	❑	❑	_____
With medication mgmt. *(up to 50 minutes)*	**90807**	❑	❑	❑	❑	❑	❑	_____	❑	❑	❑	_____

Notes to patient: Approval of this treatment plan does not guarantee payment of benefits. Final determination is based upon plan eligibility, applicable deductibles, coinsurance, copayments, and plan limits. By signing below, you acknowledge that you have been educated about your diagnosis, its cause, and its nature and duration, and you understand your consumer role in treatment. Your signature below is requested but is not required for preauthorization of services.

_____ _____

(Patient's/Guardian's Signature if Patient is a Minor) Date

_____ _____

(Provider's Signature) Date