



FROM



sunflower health plan.

SUBMIT TO: Utilization Management Department PHONE 1.844.518.9505 FAX 1.844.811.5380

OUTPATIENT TREATMENT REQUEST FORM

Please print clearly – incomplete or illegible forms will delay processing.

Date _____

MEMBER INFORMATION

First Name _____

Last Name _____

DOB _____

Member ID # _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID # _____

Provider/Agency NPI Sub Provider # _____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary (Required) _____

Secondary _____

Tertiary _____

Additional _____

Additional _____

Has contact occurred with PCP? Yes No

Date first seen by provider/agency _____

Date last seen by provider/agency _____

SPMI/SED Yes No

FUNCTIONAL OUTCOMES (TO BE COMPLETED BY PROVIDER DURING A FACE-TO-FACE INTERVIEW WITH MEMBER OR GUARDIAN. QUESTIONS ARE IN REFERENCE TO THE PATIENT.)

- 1. In the last 30 days, have you had problems with sleeping or feeling sad?
2. In the last 30 days, have you had problems with fears and anxiety?
3. Do you currently take mental health medicines as prescribed by your doctor?
4. In the last 30 days, has alcohol or drug use caused problems for you?
5. In the last 30 days, have you gotten in trouble with the law?
6. In the last 30 days, have you actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
7. In the last 30 days, have you had trouble getting along with other people including family and people outside the home?
8. Do you feel optimistic about the future?

Children Only:

- 9. In the last 30 days, has your child had trouble following rules at home or school?
10. In the last 30 days, has your child been placed in state custody (DCBS or DJJ)?

Adults Only:

- 11. Are you currently employed or attending school?
12. In the last 30 days, have you been at risk of losing your living situation?

Therapeutic Approach/Evidence Based Treatment Used _____

LEVEL OF IMPROVEMENT TO DATE

- Minor Moderate Major No progress to date Maintenance treatment of chronic condition

Barriers to Termination

Treatment Plan Changes

SUBMIT TO:
Utilization Management Department
 PHONE 1.844.265.1278 FAX 1.844.811.5380

Member Name _____

SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity/Inattn.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Psychotic Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angry Outbursts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (include severity): _____				
					Risk of OOH Placement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTIONAL IMPAIRMENT RELATED SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug(s) of Choice _____				
Last Date of substance use: _____					Attending AA/NA	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

RISK ASSESSMENT

Suicidal	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Planned	<input type="checkbox"/> Imminent Intent	<input type="checkbox"/> History of self-harming behavior
Homicidal	<input type="checkbox"/> None	<input type="checkbox"/> Ideation	<input type="checkbox"/> Planned	<input type="checkbox"/> Imminent Intent	<input type="checkbox"/> History of harm to others
Safety Plan in place? (If plan or intent indicated):	<input type="checkbox"/> Yes		<input type="checkbox"/> No		
Medical Psychiatric Evaluation completed?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		
If prescribed medication, is member compliant?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		

CURRENT MEASUREABLE TREATMENT GOALS

Optional: Please provide a narrative or any additional documentation you feel will support this request.

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

SERVICE	FREQUENCY	INTENSITY	REQUESTED START	ANTICIPATED COMPLETION
Behavioral Health Outpatient Services	How Often Seen	# Units Per Visit	Date for this Auth	Date of Service
<input type="checkbox"/> Individual Psychotherapy — Mental Health				
<input type="checkbox"/> Individual Psychotherapy — Substance Use Disorder				

Clinician Printed Name _____ Date _____

Clinician Signature _____ Date _____

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