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[[/Time]] Patient First Seen For
This Episode Of Treatment __/__/____[[@____:_____am/pm]]

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)____
____
____

<u>Complete the following if substance use is present for higher level of care requests:</u>
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

<u>Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests</u>**:**
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: ____
____
____