AmeriHealth Caritas Delaware

Behavioral Health Outpatient Treatment Request Form (OTR)

Submit to: Behavioral Health Utilization Management
Fax: 1-877-234-4273
For assistance, please call: 1-855-301-5512

Please note: Out-of-network providers require a prior authorization for all services. If you have a question about services that require prior authorization, please contact AmeriHealth Caritas Delaware behavioral health Utilization Management (BH UM) at 1-855-301-5512. Incomplete or illegible forms will delay processing.

Electroconvulsive therapy (ECT), TMS, and vagus nerve stimulation (VNS) are to be requested using the forms specific to those services.

MEMBER INFORMATION	
Member name:	
Medicaid or other health plan number:	
Date of birth:	Last authorization number (if applicable):

PROVIDER INFORMATION	
Provider name:	
☐ In network ☐ Out of network ☐ In credentialing process	
Group or agency name:	
Provider credential: ☐ M.D. ☐ Ph.D. ☐ LMHP ☐ LAC ☐ NP ☐ Other, please specify:	
Physical address:	
Phone number:	Fax number:
Medicaid/provider/NPI number:	Contact name:
If out of network, please complete the fields below: (Utilization Management will contact the provider directly before giving an authorization.) 1. Specialty of provider to meet the needs of the member: 2. Continuity of care concerns: 3. Accessibility and availability of provider: 4. Clinical rationale:	
Previous or current BH/SA treatment: ☐ None **or** ☐ MH/SUD OPT ☐ MH/SUD IOP ☐ MH/SUD PHP ☐ MH IP ☐ SUD residential ☐ Other (provide specifics):	
Substance abuse: ☐ None ☐ By history or ☐ Current or active Tobacco abuse: ☐ None ☐ By history or ☐ Current or active Substance(s) used, amount, frequency, and last used:	
Previous or current waiver services: ☐ Yes ☐ No If yes, give specifics:	
DSM diagnosis: Primary diagnosis: Secondary diagnosis: Medical diagnosis:	
Primary care physician (PCP) and other communication: Has information been shared with the PMP/other providers regarding: 1. The initial evaluation and treatment plan? ☐ Yes ☐ No 2. The updated evaluation and treatment plan? ☐ Yes ☐ No	
Other behavioral health provider names and last notified:	
PCP name:	Date last notified:
If no, please explain:	

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PROVIDER INFORMATION

Is the member's family and support system involved in treatment planning and treatment? ☐ Yes ☐ No

If no, explain:

Was the member given a choice in their behavioral health or substance abuse provider? ☐ Yes ☐ No

If no, explain:

CURRENT RISK AND LETHALITY

Suicidal	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme	Medications: Is the member prescribed medications?
Homicidal	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme	☐ Yes ☐ No Prescribing physician(s) name(s):
Assault or violence	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme	Is the member compliant with medications? ☐ Yes ☐ No Please list medications and dosages:

Treatment request: ☐ Individual ☐ Group ☐ Family ☐ Medical Management

☐ Other (please specify):

Presenting problem (list primary complaint or problem to be addressed):

Treatment plan and goals (list measurable treatment goals):

Overall progress toward goals: ☐ 1 None or minimal ☐ 2 Moderate ☐ 3 Met

Compliance with treatment: ☐ 1 None or minimal ☐ 2 Moderate ☐ 3 Met

Number of sessions requested:	Frequency of visits:	CPT/HCPC codes:
Start date:	Estimated end date:	

Provider or requestor signature:

Date: