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OUTPATIENT TREATMENT REQUEST (OTR)

For Non-Participating Providers

DATE_____

SUBMIT TO:
Cenpatico
12515-8 Research Blvd., Suite 400
Austin, TX 78759
FAX: 866-279-1358

MEMBER INFORMATION

NAME _____

DATE OF BIRTH _____

MEMBER ID # _____

HEALTH PLAN _____

PROVIDER INFORMATION

PROVIDER NAME _____

PROVIDER TAX ID # _____

PROVIDER NPI/Sub Provider # _____

PHONE _____ FAX _____

DSM-IV TR DIAGNOSIS

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____

Has contact occurred with PCP?

☐ YES ☐ NO

DATE FIRST SEEN _____

DATE LAST SEEN _____

SPMI/SED ☐ YES ☐ NO

FUNCTIONAL OUTCOMES

1. In the last 30 days, have you had problems with sleeping or feeling sad? ☐ Yes (5) ☐ No (0)
2. In the last 30 days, have you had problems with fears and anxiety? ☐ Yes (5) ☐ No (0)
3. Do you currently take mental health medicines as prescribed by your ☐ Yes (5) ☐ No (0)
4. In the last 30 days, has alcohol or drug use caused problems for you? ☐ Yes (0) ☐ No (5)
5. In the last 30 days, have you gotten in trouble with the law? ☐ Yes (5) ☐ No (0)
6. In the last 30 days, have you actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
   ☐ Yes (0) ☐ No (5)
7. In the last 30 days, have you had trouble getting along with other people including family and people outside the home?
   ☐ Yes (5) ☐ No (0)
8. Do you feel optimistic about the future? ☐ Yes (0) ☐ No (5)

Children Only:

9. In the last 30 days, has your child had trouble following rules at home or school? ☐ Yes (5) ☐ No (0)
10. In the last 30 days, has your child been placed in state custody (DCBS or DJJ)? ☐ Yes (5) ☐ No (0)

Adults Only:

11. Are you currently employed or attending school? ☐ Yes (0) ☐ No (5)
12. In the last 30 days, have you been at risk of losing your living situation? ☐ Yes (5) ☐ No (0)

THERAPEUTIC APPROACH/EVIDENCE BASED TREATMENT USED _____

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LEVEL OF IMPROVEMENT TO DATE

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

BARRIERS TO DISCHARGE _____

TREATMENT PLAN CHANGES _____

SYMPTOMS

	Mild	Moderate	Severe		Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	Hyperactivity/Inattn.	☐	☐	☐
Decreased Energy	☐	☐	☐	Irritability/Mood Instability	☐	☐	☐
Delusions	☐	☐	☐	Impulsivity	☐	☐	☐
Depressed Mood	☐	☐	☐	Hopelessness	☐	☐	☐
Hallucinations	☐	☐	☐	Other Psychotic Symptoms	☐	☐	☐
Angry Outbursts	☐	☐	☐	Risk of OOH Placement	☐	☐	☐

Other (include severity): _____

FUNCTIONAL IMPAIRMENT

	Mild	Moderate	Severe		Mild	Moderate	Severe
Severe ADLs	☐	☐	☐	Physical Health	☐	☐	☐
Relationships	☐	☐	☐	Work/School	☐	☐	☐
Substance Abuse	☐	☐	☐	Drug(s) of Choice: _____			

Last Date of Substance use:_____ Attending AA/NA: ☐ Yes ☐ No

RISK ASSESSMENT

Suicidal: ☐ None ☐ Ideation ☐ Plan ☐ Imminent Intent ☐ History of self-harming

Homicidal: ☐ None ☐ Ideation ☐ Plan ☐ Imminent Intent ☐ History of self-harming

Safety Plan in place? (if plan or intent indicated): ☐ Yes ☐ No

Medical Psychiatric Evaluation completed? ☐ Yes ☐ No

If prescribed medication, is member compliant? ☐ Yes ☐ 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: HOW OFTEN SEEN	INTENSITY: # UNITS PER VISIT	REQUESTED START DATE FOR THIS AUTH	ANTICIPATED COMPLETION DATE OF SERVICE
Behavioral Health Outpatient Services				
☐ Individual Psychotherapy – Mental Health				
☐ Individual Psychotherapy – Substance Use Disorder				

PROVIDER NAME PROVIDER SIGNATURE DATE

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