



Preauthorization for Outpatient Treatment Request



Patient's Name: Martha Washington		Sponsor SSN: 123-45-6789			
Completed By: George Washington		Date Completed: 07/04/1999			
1. Is the Patient Active Duty: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no		2. Patient DOB: 07 04 1947 Age: 60			
3. Patient Address: 4444 Doghouse Ln. City: Desert Rock		Telephone: 310 123-9999 State: CA Zip: 98112			
4. Sponsor Name: John Smith		Telephone:			
5. Other Insurance: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no If yes, please specify:					
6. Provider Name: John Adams		License Type: PhD			
7. Provider Telephone: 310 555-9999		Fax: 310 555-8888			
8. Provider Address: 222 Prairie Vale Dr. City: Desert Rock State: CA Zip: 98112					
9. Provider SSN:		TIN: 101010101	NPI: 1234567892		
10. DSM IV Diagnosis (Please complete all axes)					
Axis I: <u>312.34</u>		Axis III (medical problems):	<u>Diverticulitis/high blood pressure</u>		
Axis I: <u>300.21</u>		Axis IV (psychosocial stressors):	<u>Primary support group, economic, occupational</u>		
Axis II: <u>None V71.09</u>		Axis V (current/past GAF score):	<u>42 / 80</u>		
11. Has the patient had a psychiatric hospitalization in the last 90 days: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no					
12. Check all that apply:					
<input checked="" type="checkbox"/> Anger/Aggressiveness	<input type="checkbox"/> Dissociative states	<input type="checkbox"/> Insight and judgment problems	<input checked="" type="checkbox"/> Poor concentration		
<input checked="" type="checkbox"/> Anxiety	<input type="checkbox"/> Elevated mood	<input type="checkbox"/> Non-compliance with treatment	<input type="checkbox"/> Pressured speech		
<input checked="" type="checkbox"/> Appetite disturbance	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Obsessions and compulsions	<input checked="" type="checkbox"/> Severe mood swings		
<input type="checkbox"/> Cognitive impairment	<input checked="" type="checkbox"/> Hopelessness, helplessness	<input type="checkbox"/> Oppositional defiant	<input type="checkbox"/> Sleep disturbance		
<input type="checkbox"/> Decreased energy	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Orientation, memory problems	<input type="checkbox"/> Somatic complaints		
<input type="checkbox"/> Delusions	<input checked="" type="checkbox"/> Impulsivity	<input checked="" type="checkbox"/> Panic attacks	<input type="checkbox"/> Substance abuse, current		
<input type="checkbox"/> Depression		<input checked="" type="checkbox"/> Paranoia	<input type="checkbox"/> Substance abuse, prior		
<input checked="" type="checkbox"/> Danger to others, explain: <u>Throws things at family, and destroys property within home w/minor provocation</u>					
<input type="checkbox"/> Danger to self, explain:					
<input checked="" type="checkbox"/> Other, please list: <u>Refuses to leave home without family, past 3 months</u>					
13. Progress in treatment: <input type="checkbox"/> Improved <input type="checkbox"/> Little or no progress <input checked="" type="checkbox"/> Regressed due to new stressor <input type="checkbox"/> Near completion					
14. Explain lack of improvement and changes to treatment: <u>recent job loss, financial hardship, strained relationship with spouse</u>					
15. What type of treatment are you rendering (Cognitive, DBT, etc.): <u>CBT, Exposure tx, family tx</u>					
16. Expected length of treatment: <u>8 months</u>					
17. Treatment goals and expected outcomes for this request: <u>improved coping skills, ability to handle stress effectively. Will identify alternative ways of expressing anger/frustration; will be able to leave home alone. Will be able to complete short errands. Will identify alternative employment options</u>					
18. List all psychotropic medications and dosage patient is currently taking: <u>Effexor XR 150 mg qd, Zantac 150 mg qd, Cardizem 180 mg qd</u>					
Prescribing Clinician: <u>Jon Jones</u> <input type="checkbox"/> Psychiatrist <input type="checkbox"/> PCM <input checked="" type="checkbox"/> Other: <u>ARNP</u>					
19. Coordinating Care with: <input checked="" type="checkbox"/> Psychiatrist/ARNP <input type="checkbox"/> PCM <input type="checkbox"/> Other Therapist					
20. Planned Treatment and Interventions:					
CPT Code	Treatment	Start Date	Frequency	# of Sessions	End Date
90801	Initial Assessment				
90804	Individual Psychotherapy (25-30 min)				
90805	90804 with Medication Mgmt				
90806	Individual Psychotherapy (45-50 min)	05/01/2008	1xweek	24	11/01/2008
90807	90806 with Medication Mgmt				
90847	Family Conjoint Psychotherapy	05/01/2008	1xmonth	6	11/01/2008
90853	Group Medical Psychotherapy				
90862	Medication Management				
Other					

Provider Signature: _____ Credentials: PhD Date: 5/1/08

Please fax the completed form to: 1-866-269-5892

The form must be filled out completely for professional services. **Please note that this form should be completed for the planned treatment and interventions for this specific authorization request. Do not enter information from previous requests, i.e., treatment that has already occurred.** The following information is required on every request for service:

Patient's Name – enter the patient's name

Sponsor SSN – enter the sponsor's social security number

Completed by – enter the person's name completing the form

Date Completed – enter the date that the form was completed

1. Is the patient Active Duty – check “yes” or “no”
2. Patient DOB – Patient Date of Birth entered in month, day, full year, i.e. 07/04/1947. Age: enter patient's current age
3. Patient Address – enter the patient's street address, city, state and Zip code. *This must be a physical address. Post Office boxes are not acceptable.* Telephone – enter the patient's telephone number
4. Sponsor Name – enter the sponsor's name. The sponsor is the person that qualifies the patient for TRICARE benefits. Telephone: enter the sponsor's telephone number if different from the patient's telephone number.
5. Other Insurance – check “yes” or “no” and enter the name of the insurance. If coverage is through Medicaid, please enter “Medicaid.”
6. Provider Name – enter the servicing provider's name who will be rendering the services. License type – enter the type of license held by the servicing provider.
7. Provider Telephone – enter the servicing provider's telephone number. Fax – enter the provider's fax number.
8. Provider Address – enter the servicing provider's address, city, state and Zip code where the patient will be seen (*not the billing address*)
9. Provider SSN: (not required) TIN – enter the servicing provider's tax identification number. NPI - enter the servicing provider's National Provider Identification number.
10. DSM IV Diagnosis – please complete all five axes per the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; codes are preferred, descriptions are acceptable.
11. Has the patient had a psychiatric hospitalization in the last 90 days? – check “yes” or “no”
12. Check all that apply – check all symptoms that the patient is currently displaying. Danger to others, explain – if yes, please describe the threat/danger and recent actions. Danger to self, explain – if yes, please describe the threat/plan and recent actions. Other, please list – list other symptoms of concern and requiring treatment that are not listed above.
13. Progress in treatment: please check appropriate choice.
14. Explain lack of improvement and changes to treatment – if the patient is not improving, please note reasons identified and changes to treatment plan that have been implemented to address the lack of progress.
15. What type of treatment are you rendering (cognitive, DBT, etc.) – list type of treatment provider is rendering.
16. Expected length of treatment – note length of treatment starting **from *this auth* (not when you started treatment).**
17. Treatment goals and expected outcomes for this request, note treatment goals/outcomes expected for this specific auth request.
18. List all psychotropic medications and dosages that patient is currently taking – list medications, whether prescribed by this provider or not. Prescribing clinician – name of clinician prescribing listed psychotropic medications and license type.
19. Coordinating care with – check appropriate box(es).
20. Planned treatment and interventions – identify CPT codes to be rendered; these are the most common CPT codes requested by our providers. If the code is not there, please fill in your requested code under “other.”
Start Date – ***please note start date for this auth, not start date of entire treatment.***
Frequency – please note frequency of sessions, e.g., 1 time per week. # of sessions – total number of sessions requested for this specific authorization.
End date – end date of this authorization. You may request services for up to 180 calendar days. Additional requests can be made in the future.

Providers can register at www.triwest.com/provider for online access to the status of patient referrals and authorization requests. Please check the status of your authorization within 7-10 working days. Referring and servicing providers can check the status of both requested and approved referrals/authorizations. Providers can access the beneficiary's information, the date the request was received by TriWest, services requested, the status of requests and more.