Service Request Form for Extended Psychotherapy/Counseling

Phone Number: 1-800-818-5837 Fax Number: 1-866-617-4967

Section 1 Member Information

Member Name: (Last, First, MI)	Date of Birth: / /	Member I.D:
Address: (No., Street, City, State, Zip)		Phone Number: ( )
Service is: ☐ Initial Request ☐ Updated Request		

Section 2 Provider Information

Provider rendering services (Include Degree):	Phone Number: ( )	Fax Number: ( )
Agency:	Address: (No., Street, City, State, Zip)	
Provider/Supervising Signature (Include Degree):		
Court ordered service: ☐ Yes ☐ No (court order signed must be attached) DFPS Directed Service: ☐ Yes ☐ No (DFPS doc attached)		

Section 3 Care Coordination Contacts

Is treatment being coordinated with a PCP? ☐ Yes ☐ No If yes; Name:	Is treatment being coordinated with a psychiatrist? ☐ Yes ☐ No If yes; Name:

Section 4 DSM-IV Diagnostic Codes

Axis I (Include All):	**Axis II:**
Axis III:	**Axis IV**:
GAF: Current:	**Highest In Past 12 months:**

Section 5 Medication

Is Member on current psychiatric and/or medical medications? If yes, please complete below. Use separate sheet if more space is needed.

MEDICATION	DOSAGE	RESPONSE	MEDICATION	DOSAGE	RESPONSE

Section 6 Symptom List (Check All That Apply)

a. Psychosis: ☐ Hallucinations ☐ Delusions ☐ Loose Associations ☐ Dissociation ☐ Inappropriate Affect

b. Mood: ☐ Depressed Mood ☐ Hypomania ☐ Mania ☐ Sleep Disturbance ☐ Concentration ☐ Weight Loss/Gain ☐ Loss of Motivation/Pleasure ☐ Worthlessness / Guilt

c. Anxiety: ☐ Panic Attacks ☐ Chronic Worrying ☐ Obsessive Thoughts ☐ Compulsive Behaviors ☐ Hyper Vigilance ☐ Phobia

d. Cognitive: ☐ Dementia ☐ Delirium ☐ Distractible

e. Somatic: ☐ G. I. ☐ Pain ☐ Conversion/Pseudonuerologic

f. Development Disorders: ☐ Autism ☐ Aspergers ☐ Mental Retardation ☐ Other Learning Problems

g. Disruptive Behavior: ☐ Oppositional/Conduct ☐ Impulsivity ☐ Hyperactivity ☐ Aggressive ☐ Attention

h. Substance: ☐ Abuse ☐ Dependence (Specify Type) ____________________

i. Learning/School/Work Problems: ____________________

j. Other Symptoms (Specify) ____________________

k. Suicidal Ideation: ☐ Yes ☐ No **Homicidal Ideation:** ☐ Yes No **Other Self Harm:** ☐ Yes ☐ No

Section 7 Treatment Type / Modality / Goals (Check All That Apply)

Type:	☐ Individual	☐ Family	☐ Group
Modality:	☐ Cognitive Behavioral ☐ Chemical Dependency	☐ Interpersonal (Including Family Systems Therapy) ☐ Support / Educational	☐ Other (Specify):
Goals:	☐ Behavior/Cognitive Change ☐ Environmental/Relationship Change	☐ Mood/Affect Change ☐ Supportive Treatment (Maintain Current Functioning)	☐ Insight Into Problems ☐ Other (Specify):
Progress:	☐ Improved	☐ Unchanged	☐ Regressed

Section 8 Service Request

Date of initial visit:	# of visits:	Freq:	Duration:	CPT Code(s):

Section 9 Behavioral Health Authorization

Authorization #:	Approved # of Visits:	Approved Freq:	Approved Duration:

This is not a guarantee of benefits, only a review of the requested services for appropriateness and necessity. Reimbursement is based on the benefits available at the time of the service.

Signature : ____________________ Title: ____________________

**Please attach additional information, if necessary.*

For DALLAS Service Area STAR+PLUS Behavioral Health Services, contact NorthSTAR at 888-800-6799 or northstarcustomer@valueoptions.com

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