



**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: <input type="checkbox"/> Initial Request <input type="checkbox"/> 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): _____		

**Section 3 Care Coordination Contacts**

Is treatment being coordinated with a PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; Name: _____	Is treatment being coordinated with a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes; Name: _____
--	---

**Section 4 DSM-IV Diagnostic Codes**

<b>Axis I (Include All):</b>	<b>Axis II:</b>
<b>Axis III:</b>	<b>Axis IV:</b>
<b>GAF: Current:</b> _____ <b>Highest In Past 12 months:</b> _____	

**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)**

<b>a. Psychosis:</b>	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Delusions	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Dissociation	<input type="checkbox"/> Inappropriate Affect
<b>b. Mood:</b>	<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Hypomania	<input type="checkbox"/> Mania	<input type="checkbox"/> Sleep Disturbance	<input type="checkbox"/> Concentration
	<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Loss of Motivation / Pleasure		<input type="checkbox"/> Worthlessness / Guilt	
<b>c. Anxiety:</b>	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Chronic Worrying	<input type="checkbox"/> Obsessive Thoughts	<input type="checkbox"/> Compulsive Behaviors	
	<input type="checkbox"/> Hyper Vigilance	<input type="checkbox"/> Phobia			
<b>d. Cognitive:</b>	<input type="checkbox"/> Dementia	<input type="checkbox"/> Delirium	<input type="checkbox"/> Distractible		
<b>e. Somatic:</b>	<input type="checkbox"/> G. I.	<input type="checkbox"/> Pain	<input type="checkbox"/> Conversion / Pseudoneurologic		
<b>f. Development Disorders:</b>	<input type="checkbox"/> Autism	<input type="checkbox"/> Aspergers	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Other Learning Problems	
<b>g. Disruptive Behavior:</b>	<input type="checkbox"/> Oppositional/Conduct	<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Attention
<b>h. Substance:</b>	<input type="checkbox"/> Abuse	<input type="checkbox"/> Dependence	(Specify Type) _____		
<b>i. Learning/School/Work Problems:</b> _____					
<b>j. Other Symptoms (Specify)</b> _____					
<b>k. Suicidal Ideation:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Homicidal Ideation:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Other Self Harm:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	

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

<b>Type:</b>	<input type="checkbox"/> Individual	<input type="checkbox"/> Family	<input type="checkbox"/> Group
<b>Modality:</b>	<input type="checkbox"/> Cognitive Behavioral	<input type="checkbox"/> Interpersonal (Including Family Systems Therapy)	<input type="checkbox"/> Other (Specify):
	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Support / Educational	
<b>Goals:</b>	<input type="checkbox"/> Behavior / Cognitive Change	<input type="checkbox"/> Mood / Affect Change	<input type="checkbox"/> Insight Into Problems
	<input type="checkbox"/> Environmental / Relationship Change	<input type="checkbox"/> Supportive Treatment (Maintain Current Functioning)	<input type="checkbox"/> Other (Specify):
<b>Progress:</b>	<input type="checkbox"/> Improved	<input type="checkbox"/> Unchanged	<input type="checkbox"/> 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.*