Molina Healthcare of New Mexico
Behavioral Health Outpatient Treatment Request Form
Phone Number: (800) 377-9594
Fax Number: (888) 295-5494 • Local Fax Number (505) 924-8237

Member Information

Plan: ☐ **Molina Medicaid** ☐ **Molina Medicare** ☐ **Molina Marketplace** Date of Admission: _____

Request Type: ☐ **Initial** ☐ **Concurrent**

Member Name: _____ DOB: _____

Member ID#: _____ Member Phone #: _____

Service Is: ☐ Elective/Routine ☐ Expedited/Urgent*

***Definition of Urgent/Expedited service request designation is when the treatment requested is required to prevent serious deterioration in the member's health or could jeopardize the member's ability to regain maximum function. Requests outside of this definition should be submitted as routine/non-urgent.**

Provider Information

Provider/Facility/Clinic Name:_____ Provider NPI/Provider Tax ID#:_____

Address:_____ UR Name/Phone #: _____

Attending Psychiatrist Name:_____ Provider Tax ID#: _____

Provider Phone #: _____ Fax Number: _____

Facility Status: ☐ Par ☐ Non Par Member Court Ordered : ☐ yes ☐ no ☐ in process Court date:_____

Treatment History

Primary Care Physician:_____ Primary Care Physician Phone #: _____

Current BH provider	*Provider Name*	*Telephone Number*	*Agency*	*Last Appt.*
Therapist/Program				
Psychiatrist				

Referral/Service Type Requested

Service Is For: ☐ **Mental Health** ☐ **Substance Abuse**

☐ ED Admission: ☐ Voluntary ☐ Involuntary
☐ Direct Admission: ☐ Voluntary ☐ Involuntary
If involuntary: Court Date _____
☐ Partial Hospitalization Program

☐ Subacute Detoxification
☐ Other – Describe: _____
☐ IOP ☐ Day Program ☐ Residential
*as covered per benefit package

Primary Diagnosis for Treatment (including provisional)	
Additional Diagnoses	
Psychosocial Barriers (formerly Axis IV)	
Level of Functioning (based on a functional assessment - list tool utilized and the score)	

Procedure Code(s) & Description:_____

Length of stay requested:_____ Date(s) of Service:_____

Molina Healthcare of New Mexico
Behavioral Health Outpatient Treatment Request Form
Phone Number: (800) 377-9594
Fax Number: (888) 295-5494 • Local Fax Number (505) 924-8237

Member Name: Member ID#: DOB:

Clinical Information/Treatment Plan/Discharge Plan

Presenting/Current Symptoms that may delay or prevent discharge to lower level of care:

- ☐ Suicidal ideations
- ☐ Homicidal ideations
- ☐ Suicidal/homicidal plan
- ☐ Suicidal/homicidal attempt
- ☐ HX of Suicidal/ Homicidal actions
- ☐ PRNS
- ☐ Seclusion/Restraints
- ☐ Psychosis
- ☐ Sleep disturbances
- ☐ Appetite issues
- ☐ Significant weight gain/loss
- ☐ Poor motivation
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Cognitive deficits
- ☐ Somatic complaints
- ☐ Anger outbursts/aggressiveness
- ☐ Attention issues
- ☐ Impulsivity
- ☐ Legal Issues
- ☐ Problems with ADL's
- ☐ Social Support Problems
- ☐ Learning/School/Work
- ☐ Substance Use (include results of Tox Screens below)

Medication	*Dosage*	*New/Change from admit?*	*Compliant?*	*Therapeutic Lab Level?*

Additional information (explanation of any checked symptoms or other pertinent information):

Aftercare Plan/Follow-up Appointments

Provider Type	*Provider Name*	*Telephone Number*	*Date of Appt.*	*Time of Appt.*
Therapist/Program				
Psychiatrist				

Note: First follow-up appointment must be scheduled within seven days of discharge.

Note: LOC coverage is subject to State Contract Specific Covered Services . Please refer to State Specific Provider handbook for list of covered levels of care. Authorization for services does not guarantee payment. Payment for services are pending eligibility at the time of service and benefit coverage.

For Molina Use Only: