



		Me	ember Infor	mation					
Plan: 🗆 Molina Medicai	id								
Date of Admission:									
Request Type: 🗆 Initial	l 🗆 Con	current							
Member Name:				DOB:					
Member ID#:				Member Ph	none ‡	#:			
Service Is: Elective/Rout	ine 🗆 Exp	edited/Urgent*							
*Definition of Urgent/Expe member's health or could je as routine/non-urgent.									
		Pro	ovider Infor	mation					
Provider/Facility/Clinic Name:				Provider NPI/Provider Tax ID#:					
Contact @ Requesting Provid	ler:			Phone #:					
Address:									
Clinician Name:		Clinici	an Licensure/C	Credential:					
Provider Phone #:				Fax Numbe	er:				
			ˈreatment H	•					
Primary Care Physician:				Primary Care Physici	an Ph	none #:			
Date of First Visit:			Last Clini	ician/PCP Care Coord	linatio	on Date:			
Is treatment being coordinate	ed with the Primar	y Care Physician?	🗆 Yes 🗆 No	If Yes, Name:					
Current BH provider	Provi	Provider Name		Telephone Number		Agency Last Appt.			
Therapist/Program							2		
Psychiatrist									
		Referral	/Service Typ	oe Requested					
□ Office Visit/Therapy □ □ Medication Management □ □ Home Based Services □		ostance Abuse □ Neuropsy □ ACT □ ICM		ychological Testing		PSR ABA Tele Health Other – Describe:			
Primary Diagnosis for Treat (including provisional)	atment								
Additional Diagnoses									
Psychosocial Barriers (formerly Axis IV)									
Level of Functioning (based on a functional asses utilized and the score)	sment - list tool								
Procedure Code(s) & Descrip	otion:								
Number of days/visits author									
Number of days/visits for thi	s request:		Date(s) of	f Service for this reque	est:				





Molina Healthcare of South Carolina Behavioral Health Outpatient Treatment Request Form Provider Service Number: (855) 237-6178 Fax Number: (866) 423-3889

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

- □ Suicidal ideations
- □ Homicidal ideations
- □ Suicidal/homicidal plan
- □ Suicidal/homicidal attempt
- HX of Suicidal/ Homicidal actions
- Psychosis
 No. d lability
- □ Mood lability
- □ Anxiety
- □ Sleep disturbances

- ☐ Appetite issues
- □ Significant weight gain/loss
- □ Panic attacks
- nicidal attempt
- Poor motivationCognitive deficits
- □ Somatic complaints
- □ Anger outbursts/aggressiveness
- □ Attention issues
- □ Impulsivity

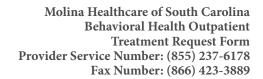
- □ Legal Issues
- □ Problems with performing ADL's
- Problems with treatment compliance
- □ Social Support Problems
- □ Learning/School/Work issues
- □ Substance Use (include results of
 - Tox Screens below)

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

Additional information (explanation of any checked symptoms or other pertinent information): See Following Page for further explanation of clinical information needed.

Note: Authorization for services does not guarantee payment. Payment for services are pending eligibility at the time of service and benefit coverage. *Below For Molina Use Only*:





Clinical Information/Treatment Plan

Please provide the following information with the fax:

Outpatient Sessions after Initial Evaluation (including home based treatment and Tele Health): *as covered per benefit package

Healthy Connections 📡

- Current treatment plan
- Summary of progress neccesitating additional sessions

Neuropsychological/Psychological Testing: *as covered per benefit package

- Diagnoses and neurological condition and/or cognitive impairment (suspected or demonstrated)
- Description of symptoms and impairment
- Member and Family psych /medical history
- Documentation that medications/substance use have been ruled out as contributing factor
- Test to be administered and # of hours requested, over how many visits and any past psych testing results
- What question will testing answer and what action will be taken/How will treatment plan be affected by results

Enhanced Outpatient Services (including ACT, PSR, ABA ICM, Foster Care Treatment)*as covered per benefit package: Initial:

- Diagnosis (suspected or demonstrated)
- Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.)
- Personal and family psychiatric medical history (comprehensive assessment/History and Physical are acceptable)
- Medication review
- Known barriers to treatment and other psychosocial needs identified
- Treatment plan including ELOS and discharge plan

Concurrent:

- Current treatment plan/goals
- Progress notes from last 5 visits/sessions (therapy and medication reviews)
- Review/Updated history of personal and family psychiatric and medical history
- ELOS and Discharge Plan
- Additional supports needed to implement discharge plan

ECT

Acute/Short-Term: *as covered per benefit package

- Acute symptoms that warrant ECT (specific symptoms of depression, acute mania, psychosis, etc.)
- ECT indications (acute symptoms refractory to medication or medication contraindication)
- Informed consent from patient/guardian (needed for both Acute and Continuation)
- Personal and family medical history (update needed for Continuation)
- Personal and family psychiatric history (update needed for Continuation)
- Medication review (update needed for Continuation)
- Review of systems (update needed for Continuation)
- Baseline BP
- Evaluation by anesthesia provider (update needed for Continuation)
- Evaluation by ECT-privileged psychiatrist (update within last month needed for Continuation)
- Any additional workups completed due to potential medical complications

Continuation/Maintenance: *as covered per benefit package

- Information updates as indicated above
- Documentation of positive response to acute/short-term ECT
- Indications for continuation/maintenance