MOLINA HEALTHCARE Healthy Connections

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

Member Information

Plan: ☐ **Molina Medicaid**

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#: _____

Contact @ Requesting Provider: _____ Phone #: _____

Address: _____

Clinician Name: _____ Clinician Licensure/Credential: _____

Provider Phone #: _____ Fax Number: _____

Treatment History

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

Date of First Visit: _____ Last Clinician/PCP Care Coordination Date: _____

Is treatment being coordinated with the Primary Care Physician? ☐ Yes ☐ No If Yes, Name: _____

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

Referral/Service Type Requested

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

☐ Office Visit/Therapy	☐ Neuropsychological / Psychological Testing	☐ PSR
☐ Medication Management	☐ ACT	☐ ABA
☐ Home Based Services	☐ ICM	☐ Tele Health
☐ ECT	☐ Foster Care Treatment	☐ Other – Describe:

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: _____

Number of days/visits authorized to date: _____ Number of days/visits used to date: _____

Number of days/visits for this request: _____ Date(s) of Service for this request: _____

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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
- ☐ Mood lability
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Appetite issues
- ☐ Significant weight gain/loss
- ☐ Panic attacks
- ☐ Poor motivation
- ☐ Cognitive 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*:**

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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

- 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