

OUTPATIENT TREATMENT REPORT
Coventry Health Care of Nebraska

Directions: To request authorization of additional outpatient sessions, please fill out the information completely and fax to **BHS Preauthorization** at 402-351-2880. If you choose to mail this form, send the completed form to the attention of **BHS Preauthorization** at Coventry Health Care of Nebraska, 3333 Farnam Street, Suite 300, Omaha NE 68131-3406.

DEMOGRAPHICS:

Case Number: _____
 Patient Name: _____ DOB: _____
 Insurer's Name: _____ Record # _____
 Practitioner's Name/Licensure: _____
 Practitioner's Phone: _____ Fax: _____

CURRENT DSM-IV DIAGNOSIS:

AXIS I: Primary: _____
 AXIS II: _____
 AXIS III: _____
 AXIS IV: _____
 AXIS V: Current: _____ Highest in past 12 months: _____

CURRENT SIGNS AND SYMPTOMS (Circle):

Active Alcohol/Substance Use	Anger/Aggression
Delusion	Depressed Mood
Apathy	Decreased concentration/Inattention
Weight/Appetite Change	Worthlessness
Anorexia/Bulimia	Helpless/Hopeless
Fatigue/Decreased Energy	Agoraphobia/Phobia
Irritability	Anxiety
Panic Attack	Dissociation
Obsessions/Compulsions	Hyperactivity
Perpetrator of Abuse	Oppositional
Victim of abuse	Paranoia
Elevated Mood	Grief
Restlessness	Somatic Complaints
Sexual Functioning	Rapid speech
Impulsivity	Hallucination
Sleep	Disturbed thought process/content
Other: _____	

CURRENT FUNCTIONING (Circle): None Mild Moderate Severe

Family/Marital Relationships	1	2	3	4
Job/School Performance	1	2	3	4
Peer Relationships/Socialization	1	2	3	4
Financial Situation	1	2	3	4
Activities of Daily Living	1	2	3	4

Explain categories rated moderate or severe: _____

RISK ASSESSMENT (Circle):

Suicidality: None Ideation Plan Means Prior Attempt When: _____
Homicidality: None Ideation Plan Means Prior Attempt When: _____
 Psychiatric Hospitalization in past: 3months 6 months 12 months Other: _____
 Other risk behaviors: _____

MEDICATIONS:

Has patient been evaluated for medications?	Yes	No
Is patient on psychotropic medications?	Yes	No
If yes, is patient compliant with medications?	Yes	No
Is patient seeing a psychiatrist/PCP regularly?	Yes	No

List current psychotropic medications with dosage/frequency/start date:
 1. _____
 2. _____
 3. _____

TREATMENT PLAN:

_____ Improved functioning/symptom reduction and discharge from treatment
 _____ Transfer to support groups or self-help and discharge from treatment
 _____ Provide ongoing supportive counseling and maintain stabilization of symptoms
 _____ Provide ongoing medication management
 _____ Other: _____

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Patient Name: _____ **Case Number:** _____

NUMBER OF ADDITIONAL SESSIONS TO TERMINATION:

(Please check)

____ Less than 5 ____ 10-14
____ 5 – 9 ____ 15 or more (explain)

Frequency of sessions: Weekly Every two weeks Monthly
Other: _____

NUMBER OF SESSIONS REQUESTED:

90804 Psychotherapy for 20-30 minutes _____

90806 Psychotherapy for 45-50 minutes _____

90847 Family psychotherapy for 45-50 minutes _____

90862 Medication management _____

90805 Therapy with medication management for 20-30 min _____

90807 Therapy with medication management for 45-50 min _____

90853 Group Therapy* _____ (see below)

S9480 Intensive Outpatient Therapy: _____

For IOP: Length of sessions: _____

How many sessions per week _____

Other: _____

*Request for **Group Therapy** requires completion of Group Addendum Form.

To obtain form, contact **BHS Preauthorization** at 1-800-228-0286 x7765.

**If Group Therapy provider is a different practitioner than previously indicated:

Practitioner's Name: _____

Licensure: _____ Phone Number: _____

OTHER TREATMENT OR SERVICES PATIENT RECEIVES:

1. _____
2. _____

TREATMENT FREQUENCY:

Date first seen: _____ Date last seen: _____

Total visits seen: _____

Number of sessions used since last authorization: _____

Date you request this authorization to begin if possible: _____

PROPOSED TREATMENT:

Problem #1: _____

Measurable outcome: _____

Treatment plan: _____

Problem #2: _____

Measurable outcome: _____

Treatment plan: _____

Problem #3: _____

Measurable outcome: _____

Treatment plan: _____

Estimated discharge date: _____

Discharge plan: _____

Additional comments: _____

Practitioner's Signature: _____

Date: _____

FOR INTERNAL USE ONLY

Authorization with CPT codes: _____ Start date: _____ End date: _____

Authorized by: _____ Date: _____