Outpatient Review Form

Please Fax to Carelon Behavioral Health at 1.800.370.1116

Member Information (verify eligibility before rendering services)

Member Name:_____

Member Insurance ID:_____

DOB:_____

☐ Medicaid ☐ Medicare ☐ Healthy Kids ☐ Commercial

Gender: ☐ Male ☐ Female ☐ Other

Member Address: _____

_____

Member Phone: _____

Request is: ☐Initial ☐ Concurrent

Provider Information

Agency Name:_____

Carelon Provider ID:_____

Group NPI: _____

Tax ID: _____

Fax #:_____

Email: _____

Address: _____

_____

Contact:_____

Direct Phone #:_____Ext:_____

*This is the clinical or administrative contact person that Carelon can outreach for additional information

Current Psychotropic Medications

Are Psychotropic Meds being prescribed?

☐ Yes ☐ No ☐ Unknown

If yes, prescribed by: ☐ MD ☐ RN, CS/NP ☐ PCP

Prescriber:_____

List of Meds:_____

_____

Is Member currently compliant with meds? ☐ Yes ☐ No

Is the Member court ordered to treatment? ☐ Yes ☐ No

Is the Member SMI or SED? ☐ Yes ☐ No

DSM-V Diagnosis

1. _____
2. _____
3. _____
4. _____

Have you communicated with Member's PCP in past 12 months?

☐ Yes ☐ No With the Prescriber? ☐ Yes ☐ No ☐ N/A

Current Risk Indicators (check all that apply)

☐ Current substance abuse ☐ Fire setting

☐ Caring for ill family member ☐ Impulsive behavior

☐ Self-mutilation/cutting ☐ Assaultive behavior

☐ Sexually offending behavior ☐ Psychotic symptoms

☐ Current family violence (abuse, domestic)

☐ Coping with significant loss (job, relationship, financial)

☐ Other:_____

Risk Assessment (check all that apply)

Suicidal Tendency:

☐ Not Present ☐ Ideation ☐ Plan ☐ Means

☐ Prior attempt (date):_____

Homicidal Tendency:

☐ Not Present ☐ Ideation ☐ Plan ☐ Means

☐ Prior attempt (date):_____

Rate member's level of psychological distress:

☐ 1 (minimal) ☐ 2 (mild) ☐ 3 (moderate) ☐ marked ☐ sever

(Please rate the member's response to treatment since last review or since start of treatment if this is first report.)

Behavioral Symptoms that are focus of treatment:

☐ Much Worse ☐ Slightly ☐ Worse ☐ No Changes

☐ Slight Improvement ☐ Major Improvement

Ability to perform work/school/household tasks:

☐ Much Worse ☐ Slightly ☐ Worse ☐ No Changes

☐ Slight Improvement ☐ Major Improvement

Current Risk of Psychiatric Hospitalization:

☐ 1(low) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high). If 3 or higher, explain:____

_____

Updated targeted goals for episode of care (must be member and service specific):		
N = New Goal 1 = Much Worse 2 = Somewhat Worse 3 = No Change 4 = Slight Improvement 5 = Major Improvement R = Resolved		
Goals	Modality	Progress (Rating #)
1.		
2.		

Brief Clinical Summary (REQUIRED: additional clinical information should be attached, if needed):

Request for Services- Traditional OP Therapy and Medication Management - IF UNABLE TO USE E-SERVICES

Service	CPT Code(s)	# of Units	Start Date	End Date
Medication Management				
Individual, Family, Group Therapy				
Evaluation				
Other				

Request for Services- Community Support Services – IF UNABLE TO USE E-SERVICES

Service	CPT Code(s)	# of Units	Start Date	End Date
Targeted Case Management (Adult, Child, Intensive)				
TBOS (21 and under) (Therapy, Beh Man, Support Service)				
Psychosocial Rehabilitation				
Clubhouse				
Other				