Behavioral Health Care Management

Extension Mental Health Treatment Request

COMPLETE ALL SECTIONS (A-J) See Accompanying Instructions on Page 3

2650 Novation Parkway
Madison, WI 53713
Phone (800) 683-2300
(608) 640-4450
Fax (608) 471-4391

A: MEMBER INFORMATION	
Name:	Date of Birth:
Member Number:	

B: TREATING PROVIDER INFORMATION		
Facility Name:	Provider Name:	
Facility Address:		
Contact Name:	Phone:	Fax:

C: TYPE OF SERVICE BEING REQUESTED

☐Inpatient ☐Residential ☐PHP ☐IOP ☐In-Home ☐Outpatient ☐Other *(specify):*

☐TMS **(STOP - Complete Separate TMS Request Form)**

D: SERVICE INFORMATION ☐Mental Health ☐Dual ☐Eating Disorder **(ADDITIONAL EATING DISORDER FORM MUST BE COMPLETED)**	
Number of Visits/Days Requested:	Begin/End Date of Requested Service: ___/___/___ to ___/___/___ (mm dd yy mm dd yy)

E: DSM-5/ICD-10 CODES AND DESCRIPTION	
Code:	***Description:***

F: BRIEF TREATMENT SUMMARY & INTERVENTIONS USED *(progress & symptoms since last review – include additional pages if needed)*

G: CURRENT RISK

Suicidal: ☐None ☐Current Ideation ☐Active Plan ☐Current Intent ☐Access to Lethal Means ☐Current Suicide Attempt ☐Prior Suicide Attempt **Explain any checked boxes:**_____

_____

Homicidal/Violent: ☐None ☐Current Ideation ☐Active Plan ☐Current Intent ☐Access to Lethal Means ☐Current Threat to Others ☐Prior Acts of Violence **Explain any checked boxes:**_____

_____

Self-Injurious Behavior: ☐None ☐Thoughts ☐Actions Describe:_____ _____

Date of Last Occurrence:_____

Was Medical Attention Required?: ☐Yes ☐No

H: CURRENT FUNCTIONAL IMPAIRMENTS *Related to areas of social, occupational, scholastic and/or other role functioning*

Self-Care/ADLs/IADLs: ☐unable to structure day time hours ☐poor hygiene ☐medication nonadherence
☐unable to perform key life tasks (chores, meal prep, etc) ☐unable to follow instructions/negotiate needs
☐ unable/difficulty caring for dependents **Specific Examples and Time Frames of Problem Areas**:_____
_____

Current School/ Work Status: ☐frequent absences ☐suspended/on leave ☐expelled/terminated
☐unable to meet obligations/decreased productivity **Explain any checked boxes:**_____
_____

Psychosocial/Home Environment: ☐ supportive ☐ directly undermining ☐ home risk/safety concerns ☐ homelessness ☐ lives alone
☐ increasing isolation/isolative ☐ impaired family/peer relationships **Explain any checked boxes**:
_____

Additional Concerns:_____
_____

I: CURRENT SYMPTOMS AND CORRESPONDING EXAMPLE

Psychosis	☐ Hallucinations ☐Command Hallucinations ☐ Delusions ☐Loose Association ☐Dissociation ☐Inappropriate Affect ☐Paranoia ☐Decreasing Reality Orientation ☐Disorganized Behavior ☐Bizarre Behaviors Examples: _____ _____
Mood	☐Depression ☐Hypomania ☐Mania ☐Concentration ☐ Weight Loss/Gain ☐Isolating ☐Sleep Disturbances ☐Worthlessness/Guilt ☐Loss of Motivation/Pleasure ☐Hopelessness Examples: _____ _____
Anxiety *OCD* *PTSD*	☐Panic Attacks ☐Chronic Worrying ☐Obsessive Thoughts ☐ Compulsive Behaviors ☐Hypervigilance ☐Phobia ☐Flashbacks ☐PTSD-Associated Symptoms (identify) Examples: _____ _____
Cognitive	☐Dementia ☐Delirium ☐Distractible ☐Poor Decision Making/Judgment Examples: _____ _____
Development Disorders	☐Autism Spectrum ☐Cognitive Impairment Examples: _____ _____
Disruptive Behaviors	☐Oppositional/Conduct ☐Impulsivity ☐Hyperactivity ☐Aggressive ☐Attention ☐Angry Outbursts Examples: _____ _____
Substance	☐Use ☐Abuse Specify:_____
Other Symptoms	Specify:_____ _____

J: SPECIFY MEDICATION CHANGES SINCE LAST REVIEW *(If PRN, specify use and frequency)*

Instructions for BHCM Extension Mental Health Treatment Form

A. **MEMBER INFORMATION:** Name **and** Date of Birth are **essential**—please ensure correct spelling and DOB; lack of this identifying information will delay processing.
Member Number: This is the individual's Insurance ID number. It is okay to leave blank if you don't have this information.

B. **TREATING PROVIDER INFORMATION:** This is the name of the provider/facility who is currently providing services and requesting additional authorization. Please provide contact name, phone number, **&** fax number of the person submitting the request.

C. **TYPE OF SERVICE BEING REQUESTED:** Identify current level of care requiring additional authorization.

D. **SERVICE INFORMATION:**
Mental Health: Any non-AODA mental health condition
Dual: Any program that specifically addresses AODA issues within the context of a mental health condition
Eating Disorder: There is a supplemental form that also needs to be completed if the individual is receiving treatment specifically for an eating disorder.
Number of Visits/Days Requested: This identifies how many additional visits or days of treatment are being requested.
Begin/End Date of Requested Service: This identifies the dates of services you are requesting to be covered in this current request.

E. **DSM-5/ICD-10 CODES AND DESCRIPTION:** Provide specific code as well as any subtypes and/or specifiers.

F. **BRIEF TREATMENT SUMMARY & INTERVENTIONS USED:** Do **NOT** include the entire chart. This should be a summary of how the patient is progressing and what treatment interventions are being utilized. Specific examples of symptoms & situations are helpful.

G. **CURRENT RISK:** Specific examples are **required**.

H. **FUNCTIONAL IMPAIRMENTS:** Specific examples are **required**.

I. **SYMPTOMS AND CORRESPONDING EXAMPLE(S):** Specific examples are **required**.

J. **SPECIFY MEDICATION CHANGES SINCE LAST REVIEW:** Specifically identify changes made since the last review, including reasons for and adjustments to medication change(s). If a PRN has been prescribed, identify frequency of use since last review.