# Behavioral Health Care Management Extension Mental Health Treatment Request

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**QuartzBenefits.com**

Please write clearly and legibly — complete all sections.
See accompanying instructions on pages 3 and 4.

## A: MEMBER INFORMATION

| | |
|---|---|
| Name: | Date of Birth: |
| Member Number: | |

## B: REQUESTED TREATMENT 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 AND INTERVENTIONS USED

Progress and 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: CURENT 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: PRIMARY SYMPTOMS AND CORRESPONDING EXAMPLE

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

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

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|---|
| |
| |
| |
| |

## 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 Quartz Insurance ID number. It is okay to leave blank if you don't have this information.

B. **TREATING PROVIDER INFORMATION:** This is the provider / facility / program who is currently providing services and requesting additional authorization. Please provide contact name, phone number and 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 AND 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 AND 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. **SPECIFIC 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.