Behavioral Health Care Management
Initial Mental Health Treatment Request

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

2650 Novation Parkway ▪ Madison, WI 53713
(800) 683-2300 ▪ Fax (608) 471-4391
QuartzBenefits.com

A: MEMBER INFORMATION

Name:	Date of Birth:
Member Number:	

B: REFERRAL SOURCE / REQUESTING CLINICIAN

Provider Name:	Phone:	Fax:
Facility / Clinic Name:	Last Date Seen by Referring Provider:	

C: REQUESTED TREATMENT PROVIDER INFORMATION

Facility Name:	Provider Name:	
Facility Address:		
Contact Name:	Phone:	Fax:

D: TYPE OF SERVICE BEING REQUESTED

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

☐TMS (STOP – Complete Separate TMS Request Form)

E: 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

F: DSM-5 / ICD-10 CODES AND DESCRIPTION

Code:	Description:

G: BRIEF DESCRIPTION AND REASON FOR TREATMENT REQUEST

Be specific and provide examples – use additional pages if needed.

H: 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

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I: 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:____

____

J: PRIMARY 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:____

K: CURRENT MEDICATIONS AND PRESCRIBER (If PRN, specify use and frequency)

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Instructions for BHCM Initial 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. **REFERRAL SOURCE / REQUESTING CLINICIAN:** This is the name of the provider / facility completing this form. Please provide your phone number and fax number.

C. **REQUESTED TREATMENT PROVIDER INFORMATION:** This is the provider / facility / program to whom the member is being referred.

   Facility Name / Provider Name: Include both if you have them; if you only know the program / facility you're referring to, put that information in this space.

   Facility Address: If this is a Quartz in-network provider, please be sure to put the city name for location. If this is an out-of-network location (non-Quartz provider), please include the address of the facility.

   Contact Name / Phone / Fax: If you are a facility / program making an internal referral, please complete this information for the Requested Treatment program. If you are referring to a provider / program outside of your own facility, it is okay to leave blank.

D. **TYPE OF SERVICE BEING REQUESTED:**

   TMS: Do not use this form to request PA for TMS. BHCM can provide you with a specific form if you are requesting authorization for TMS.

   Outpatient: Outpatient requests are used for outpatient psychotherapy or medication management. A prior authorization (PA) is only required if the request is for services with an out-of-network provider.

   In-Home Family Therapy: The intent of the services is to provide the clinical intervention and support necessary to successfully maintain a child or adolescent in their home / community. In-home services can be utilized with families where providing services in the home is the most effective strategy for addressing a specific symptom or issue.

   Intensive Outpatient Program (IOP): IOP can be offered in the day or evening hours and can be a step-down from a more restrictive level of care or a step-up to prevent a need for a more restrictive level of care. Treatment is a minimum of 9 hours per week.

   Partial Hospital Program (PHP): A PHP is a less restrictive alternative to inpatient care for individuals presenting with acute symptoms of a severe psychiatric disorder who cannot be effectively treated in a less restrictive level of care and would otherwise require inpatient treatment. Often, PHP is recommended when an individual is unable to work, attend school, and / or parent due to the intensity of their symptoms. Treatment is typically 5 or more days per week, 5 or more hours per day.

   Residential: Residential provides medical monitoring and 24-hour individualized treatment to a group of individuals. Residential is recommended when an individual is experiencing functional impairments in both relationships and performance of daily role(s). There is a lack of evidence to support the effectiveness of this level of treatment over less restrictive levels of care for individuals with a viable living environment; therefore, it is only recommended in cases where an individual cannot be managed safely in the community yet doesn't require the services of an inpatient hospitalization.

   Inpatient: Inpatient refers to acute psychiatric treatment in an acute care or psychiatric hospital unit. Inpatient hospitalization provides 24-hour medical monitoring and psychiatric treatment.

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E. 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 being referred specifically to an eating disorder program.

Number of Visits / Days Requested: This is typically only completed by a program / facility. Individual providers can leave this section blank.

Begin / End Date of Requested Service: This is typically only completed by a program / facility. Individual providers can leave this section blank.

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

G. BRIEF DESCRIPTION AND REASON FOR CURRENT TREATMENT REQUEST: Specific examples of symptoms and situation are helpful.

H. CURRENT RISK: Specific examples are required.

I. FUNCTIONAL IMPAIRMENTS: Specific examples are required.

J. PRIMARY SYMPTOMS AND CORRESPONDING EXAMPLE(S): Specific examples are required.

K. CURRENT MEDICATIONS AND PRESCRIBER: Specify any recent changes or significant information.

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