Behavioral Health Care Management
Initial Mental Health Treatment Request

Please write clearly and legibly — complete all sections.
See accompanying instructions on pages 4 and 5.

Quartz®

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A. MEMBER INFORMATION

Name:	Date of Birth:
Quartz Insurance ID Number:	Member Phone 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
Include Procedure/HCPCS codes being requested

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

☐ TMS (STOP – Complete Separate TMS Request Form)

Procedure/HCPCS Code(s) for requested service(s):

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:

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G. BRIEF DESCRIPTION AND REASON FOR TREATMENT REQUEST
Be specific and provide examples – include 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

I. FUNCTIONAL IMPAIRMENTS
Related to areas of social, occupational, scholastic and/or another 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:**

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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.

Quartz Insurance ID number: This is the individual's 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

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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.

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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