

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		
<input type="checkbox"/> Inpatient <input type="checkbox"/> Residential <input type="checkbox"/> PHP <input type="checkbox"/> IOP <input type="checkbox"/> In-Home <input type="checkbox"/> Outpatient <input type="checkbox"/> Other (specify):		
<input type="checkbox"/> TMS (STOP – Complete Separate TMS Request Form)		
E: SERVICE INFORMATION <input type="checkbox"/> Mental Health <input type="checkbox"/> Dual <input type="checkbox"/> 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: <input type="checkbox"/> None <input type="checkbox"/> Current Ideation <input type="checkbox"/> Active Plan <input type="checkbox"/> Current Intent <input type="checkbox"/> Access to Lethal Means <input type="checkbox"/> Current Suicide Attempt <input type="checkbox"/> Prior Suicide Attempt Explain any checked boxes: _____		
Homicidal / Violent: <input type="checkbox"/> None <input type="checkbox"/> Current Ideation <input type="checkbox"/> Active Plan <input type="checkbox"/> Current Intent <input type="checkbox"/> Access to Lethal Means <input type="checkbox"/> Current Threat to Others <input type="checkbox"/> Prior Acts of Violence Explain any checked boxes: _____		
Self-Injurious Behavior: <input type="checkbox"/> None <input type="checkbox"/> Thoughts <input type="checkbox"/> Actions Describe: _____ Date of Last Occurrence: _____		
Was Medical Attention Required?: <input type="checkbox"/> Yes <input type="checkbox"/> No		

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	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Command Hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Loose Association <input type="checkbox"/> Dissociation <input type="checkbox"/> Inappropriate Affect <input type="checkbox"/> Paranoia <input type="checkbox"/> Decreasing Reality Orientation <input type="checkbox"/> Disorganized Behavior <input type="checkbox"/> Bizarre Behaviors Examples: _____
-----------	---

Mood	<input type="checkbox"/> Depression <input type="checkbox"/> Hypomania <input type="checkbox"/> Mania <input type="checkbox"/> Concentration <input type="checkbox"/> Weight Loss / Gain <input type="checkbox"/> Isolating <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Worthlessness / Guilt <input type="checkbox"/> Loss of Motivation / Pleasure <input type="checkbox"/> Hopelessness Examples: _____
------	---

Anxiety OCD PTSD	<input type="checkbox"/> Panic Attacks <input type="checkbox"/> Chronic Worrying <input type="checkbox"/> Obsessive Thoughts <input type="checkbox"/> Compulsive Behaviors <input type="checkbox"/> Hypervigilance <input type="checkbox"/> Phobia <input type="checkbox"/> Flashbacks <input type="checkbox"/> PTSD-Associated Symptoms (identify) Examples: _____
------------------------	---

Cognitive	<input type="checkbox"/> Dementia <input type="checkbox"/> Delirium <input type="checkbox"/> Distractible <input type="checkbox"/> Poor Decision Making / Judgment Examples: _____
-----------	---

Development Disorders	<input type="checkbox"/> Autism Spectrum <input type="checkbox"/> Cognitive Impairment Examples: _____
-----------------------	---

Disruptive Behaviors	<input type="checkbox"/> Oppositional / Conduct <input type="checkbox"/> Impulsivity <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Aggressive <input type="checkbox"/> Attention <input type="checkbox"/> Angry Outbursts Examples: _____
----------------------	--

Substance	<input type="checkbox"/> Use <input type="checkbox"/> Abuse Specify: _____
-----------	---

Other Symptoms	Specify: _____
----------------	----------------

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

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.

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.