Behavioral Health Care Management Extension Mental Health Treatment Request

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

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

A. MEMBER INFORMATION

Name:	Date of Birth:
Quartz Insurance ID Number:	Member Phone Number:

B. REQUESTED TREATMENT PROVIDER INFORMATION

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

C. 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):

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.

QA00988 (0622)

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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 another role functioning

Self-Care/ADLs/IADLs: ☐ unable to structure daytime 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 ☐ 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:**

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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)

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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.

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. 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.

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