BEHAVIORAL HEALTH CONNECTICUT OUTPATIENT TREATMENT REPORT

PO Box 775, Middletown, CT 06457 Phone 1-800-741-4443 Fax 1-860-704-6212

DEMOGRAPHICS

Patient's Name: ______________________________ DOB: ___/___/___

Insured's Name: __________________________ Grp #: _______________

ID#: __________________ Insurance Type: Aetna PPO – HH ( )

Practitioner/Program

Name: ____

Address: ____

City: ____________________ State: ______________ Zip: __________

Telephone: ________________________ Fax: ________________________

Has Communication w/PCP occurred? ____ If no, please explain____

DSM IV DIAGNOSIS

Axis I: ________.______ , ________.______ , ________.______

Axis II: ________.______ , ________.______ , ________.______

Axis III: ________.______ , ________.______ , ________.______
________.______ , ________.______

Axis IV: ____

Axis V: Current:___ Highest:___ Expected:___

If depression, has the patient been screened for Substance Abuse? ☐ Yes _________(Date) ☐ No

If Substance Abuse, has the patient been screened for:

Depression? ☐ Yes __________(Date) ☐ No

Withdrawal? ☐ Yes __________(Date) ☐ No

Continued Use? ☐ Yes __________(Date) ☐ No

ASSESSMENTS

Safety Assessment: (*Please check all that apply*)

Suicidality:	Homicidality:
Γ Not Present	Γ Not Present
Γ Ideation	Γ Ideation
Γ Plan	Γ Plan
Γ Prior Attempt Date: ______	Γ Prior Attempt Date: ________

Level of Impairment

Cognitive:	None	Mild	Moderate	Severe
Reasoning/Judgment	Γ	Γ	Γ	Γ
Orientation	Γ	Γ	Γ	Γ
Memory	Γ	Γ	Γ	Γ
Concentration	Γ	Γ	Γ	Γ
Thought Content	Γ	Γ	Γ	Γ

MEDICATION

Have medications been prescribed? Γ YES Γ NO

Prescribing Physician: __________________PCP/Psychiatrist/APRN

Date of Contact with Prescriber ______________________

Current Medications	Dosage	Start Date	Compliance
1. ______________________			Y____N____
2. ______________________			Y____N____
3. ______________________			Y____N____

Previous Med Trials:
____

If Biological based diagnosis and no medication, please explain:
____

If patient is refusing, how is this being addressed?
____

CURRENT SYMPTOM	SEVERITY OF SYMPTOM
	Mild Moderate Severe 1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10
	1 2 3 4 5 6 7 8 9 10

TREATMENT

Modality Used: Please Check

Cognitive o Behavioral o Interpersonal o

Frequency (# visits per week or month)

☐ *Medication Management 90862) _______

☐ Psychotherapy 20-30 min 90804) ______

☐ with meds (90805) _________

Duration

#Visits Requested with this OTR: __________

Start Date This Auth:

	1 2 3 4 5 6 7 8 9 10	☐ Psychotherapy 45-50 min 90806) _______ ☐ with meds (90807) _________ ☐ Family Therapy 45-50 min (90847) _____ ☐ Group Therapy 60-90 min (90853) _______ ☐ Other ______________________________ *If only 90862 requested, no OTR needed. Contact BHC to register

____
Stop Date This Auth:
____
Projected Discharge Date:
____

Provider's Signature______________________________________My signature confirms that I am providing the above requested services

Providers Name (Please Print): ____ Date: ____________________ Revised: 05/01/06

Guidelines for Completing the Outpatient Treatment Report [OTR]

An Outpatient treatment report (OTR) is required PRIOR to the 8th visit. An OTR is also required if additional sessions are needed beyond what has been previously authorized.

In order to be processed all areas of the OTR must be completed. Incomplete forms will be returned to the provider.

An OTR does not need to be completed for medication management visits (90862) unless you are specifically requested to do so by BHC's Care Management Department. If this is the only service being rendered, an annual registration is all that is required in most cases.

DEMOGRAPHICS: This information is needed to ensure that authorization is accurately provided for the specific member, provider and service location.

Communication with PCP: It is important that behavioral health practitioners exchange information, upon consent of the patient, with the primary care providers. We ask that you speak with your patient about the importance of all care being coordinated. If [s]he refuses to have the PCP notified, please indicate this on the OTR. We include the PCP Collaboration Form with the OTR that is mailed to you upon initial registration.

CLINICAL STATUS: This includes information provided in the sections titled: Assessments, Current Symptoms, Severity of Symptoms, DSM IV Diagnosis and Medication (including dosage and compliance). Updating these areas on each OTR documents ongoing treatment. This information is necessary to evaluate medical necessity.

TREATMENT: In order to evaluate medical necessity, requests must specify the frequency and duration of treatment. Your request must also include a specific number of sessions to be used within a specific time span. For this reason we ask you to tell us when you will begin to use the additional sessions you are requesting [Start date this authorization] and when you project completing these sessions [Stop date this authorization]. If you project that care will be needed beyond the stop date we ask you to provide the projected date of discharge.

A new authorization should start (start date) only after the date that previously authorized visits will be used. Please note that the start date of this authorization will supercede all previous authorizations including any unused sessions.

Example: An OTR is submitted to BHC on 2/7/06. Seven visits had been previously authorized. The 7th visit will be used on 2/14/06. The start date requested on the OTR submitted on 2/7/06 should be 2/15/06.