INSTRUCTIONS FOR COMPLETING THE CARELON BEHAVIORAL HEALTH OUTPATIENT REVIEW FORM (ORF2)

This form to be used for NC Medicaid and/or Health Choice service requests

Revised January 2016

Please note: To ensure timely processing of your Outpatient Registration Form, please complete ALL sections prior to submission to Carelon Behavioral Health. TYPE or PRINT LEGIBLY. Check/circle responses where applicable.

Requested Start Date and Service Requested

Information requested	How to complete this section
Requested Start Date	Enter the date you want your authorization to start.
Service Requested	Check appropriate box: mental health or substance abuse

Member and Provider Demographics:

Information requested	How to complete this section
Member's Name	Enter name as it appears on Medicaid or Health Choice ID card
Member's Date of Birth	Enter consumer's date of birth
Member's ID #	This is the ID # from the consumer's benefit card. For Medicaid, use Medicaid #. For Health Choice, enter ID#
Member's Address	Enter consumers full street address, city and state
Insured's Employer/Benefit Plan	Enter "Medicaid" or "Health Choice"
Is the member currently receiving disability benefits?	**IGNORE THIS LINE**
Attending Provider Name/Medicaid Provider #	For all services, including Health Choice, list the name of the provider performing services (treating provider) and their individual Medicaid provider number. Enter credentials and license of provider as well. Provisionally- or Board-eligible licensed providers can bill incident to the LME or a physician. In these situations, please list the enrolled physician's Medicaid or the LME provider number. **Note: Only fully licensed providers can be authorized to provide services to Health Choice members. For NC Health Choice, authorizations will be built to this number.**
Billing Provider Name/ #	Enter the billing Medicaid Provider number associated with the Billing National provider Identifier (NPI) with which you will submit your claims. Do not submit the NPI on the ORF2.
Referring MD/LME/Medicaid #	For members under the age of 21, enter referring physician name and Medicaid # or LME name and Medicaid #.
Service Address	Enter address where services are rendered
Telephone # of Treating Provider	Enter the telephone number of treating provider.
Provider SSN or Tax ID	**IGNORE THIS LINE**

Current Risks:

Information requested	How to complete this section
Member's risk to self:	Indicate member's level of, or absence of, suicidality by circling the appropriate value. **This must be completed**
Member's risk to others:	Indicate potential for, or absence of, violence and/or abuse by circling the appropriate value. **This must be completed**

Current Impairments: (please select/circle one value for each type of impairment)

Rating	Definition
0 = none	No evidence of impairment
1 = mild	Occasional impairment or difficulties, but no interference with normal daily activities
2 = Moderate	Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks

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3 = Severe	Currently experiencing severe symptoms, potential risk of harm to self/others, severe distress and/or disruption in daily activities
na = not assessed	Impairment was not assessed – **Please note use of NA may result in additional phone calls with Carelon Behavioral Health to ascertain this information.**

Diagnosis:

Information requested	How to complete this section
Diagnosis (see ASAM dimensions next)	• List the specific DSM code and description for each Axis. Primary only is acceptable. • Axis I must be completed at minimum. Primary only is acceptable.

ASAM Dimensions:

Complete this section only if there is an SA issue. ASAM Dimensions are the determining factor for medical necessity if the request is for treatment of a substance abuse diagnosis codes. For further information about ASAM Dimensions, see the web site of the American Society of Addiction Medicine at www.asam.org	
Information requested	**How to complete this section**
Intoxicated/WD Potential	• Low – Not under the influence; no withdrawal potential • Medium – Recent use, potential for intoxication; presenting with initial withdrawal symptoms • High – Severe withdrawal history; presenting with seizures, CIWA score greater than 10
Biomedical Conditions	• Low – No current medical problems; no diagnosed medical condition; no care from PCP or prescribed meds • Medium – Diagnosed medical condition; care from PCP; problematic response to conditions and/or care • High – Life threatening medical condition; medical problems interfering with treatment; hospitalization needed
Emot/Beh/Cog Condtns	• Low – No current cognitive/emotional/behavioral conditions • Medium – Psychiatric Symptoms, including cognitive, emotional, behavioral; complications interfering with recovery efforts • High – Active DTO/s, S/HI; destructive, violent, or threatening behaviors, refusing to attend program schedule
Readiness to Change	• Low – Accepting need for treatment; attending, participating, and can ID future goals, plans • Medium – Ambivalent about treatment; seeking help to appease others; avoiding consequences • High – Denial of need for treatment despite severe consequences; refusing or is unable to engage due to DIM3, DIM5 symptoms interfering
Relapse Potential	• Low – Recognizes onset signs; uses coping skills with CD or psychiatric problems • Medium – Limited awareness of relapse triggers or onset signs • High – Beliefs problematic re: continued CD use despite attendance; revisions in treatment plan; unable to recognize relapse triggers or onset signs, or recognize and employ coping skills
Recovery Environment	• Low – Supportive Recovery environment, with accessible MH, CD Support • Medium – Moderately supportive with problematic access to MH, CD support • High – Environment does not support recovery behaviors or efforts; resides with active substance users or abusive individuals

Treatment History:

Information requested	How to complete this section
Treatment History/Psychiatric Treatment	This should **not** include any treatment that the member is currently receiving from you or any other provider.

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Treatment Compliance (Non-Med)	This is compliance with outpatient/non medical treatment, for either/both Psychiatric/Substance Abuse treatment.
Treatment History/Substance Abuse Treatment	This should **not** include any treatment that the member is currently receiving from you or any other provider.
Treatment Compliance (Non-Med)	This is compliance with outpatient/non medical treatment, for either/both Psychiatric/Substance Abuse treatment.

Treatment Plan:

Information requested	**How to complete this section**
Reason for continued treatment	Check all that apply **(this must be completed)**
Please indicate type(s) of service provided BY YOU, and the frequency	• Check all services provided by YOU to the consumer. • NO authorization is required for medication management 90862, 99408 or 99409 • Psychiatrists should use "select other" to request 90805 or 90807. • For all other categories, mark type of service, frequency, and add number of units/visits requested. Note: Use of PRN as an indicator of frequency will not be accepted. • H codes: enter H codes under other. Be sure to request frequency! (15 minutes = 1 unit.) • All providers billing through an LME must use H codes. • H codes **cannot** be authorized for Health Choice members.
Please indicate type(s) of service provided BY OTHERS	This should only include treatment the member is getting from other providers. Please check all that apply. This is the second part to the Two Aspects of Treatment.
Are the Member's family/supports involved in treatment?	This must be completed (check one)
Coordination of care with other behavioral health providers?	This must be completed (check one)
Coordination of care with medical providers?	This must be completed (check one)
Has Member been evaluated by a Psychiatrist?	This must be completed (check one)
Current Psychotropic Medications	List the consumer's primary medications, the dosage, frequency and whether or not the consumer is usually adherent. If more space is needed please list on a separate sheet of paper.
Treating Provider's Signature	• Print name, add signature including credential and license. • Be sure to date form. • MD must sign when provisionally licensed professionals are rendering services "incident to" a physician.

Did you complete and attach a Service Order to accompany this authorization?
Service Orders are valid for one year and must be signed by a MD, PhD, PA or NP.