carelon

Please Fax to Carelon Behavioral Health:
800.441.2281 / 781.994.7634

Outpatient Review Form (Adult Day Treatment)

Member information *(Verify eligibility before rendering services)*

Member name: _____ **Member ID#:** _____ **D.O.B:** _____

Provider information

Provider / agency name: _____ **Clinician name:** _____

Provider ID#: _____ **Phone number:** _____

Request for Adult Day Treatment - H2012

I request _____ **sessions, starting on:** _____ **over the next:** ○ **90 days** ○ **180 days** ○ **Other:** _____

Current psychotropic medications

Are psychotropic meds being prescribed? ○ Yes* ○ No ○ Unknown *If Yes, prescribed by: ○ MD ○ RN ○ CS/NP ○ PCP

Prescriber: _____ **List Meds:** _____

Have you communicated with the member's prescriber of psychotropic drugs?
○ Yes ○ No ○ Member declined ○ N/A; Member not on medications ○ N/A; Provider is the prescriber

Have you communicated with member's PCP? ○ Yes ○ No ○ Member declined

Have you documented the communication or member declination? ○ Yes ○ No ○ N/A; I did not contact PCP

Have you been in communication with other BH providers for this member?
○ Yes *(please specify)*: _____ ○ No ○ Member declined ○ N/A; There are no other BH providers

Site of treatment

○ Office ○ Home ○ School ○ Other *(please specify)*: _____

Additional Comments: _____

ICD-10/DSM-5 diagnoses *(Please give more than one diagnosis as necessary for clinical presentation.)*

Diagnosis: _____ Diagnosis: _____ Diagnosis: _____ Diagnosis: _____

Current risk indicators *(check all that apply)*:
☐ Current substance abuse ☐ Caring for ill family member ☐ Self-mutilating / cutting ☐ Sexually offending behavior
☐ Current family violence ☐ Fire setting ☐ Impulsive behavior ☐ Assaultive behavior ☐ Psychotic symptoms
☐ Coping with significant loss ☐ Prior Psychiatric Inpt. Admission ☐ Other *(please specify)*: _____

Status of 3 most significant objectives since treatment initiation *(Please include additional page if space provided is insufficient.)*

Objectives *(in measureable/behavioral detail)*	**Modality** *(Individual/Group)*	**Progress** *(Rating since Tx began; use scale below)*
1.		
2.		
3.		

N = New Goal 1 = Much Worse 2 = Somewhat Worse 3 = No Change 4 = Slight Improvement 5 = Much Improvement R = Resolved

Risk assessment *(Check all that apply)*

Suicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt *(please specify date)*:

Homicidality: ☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior Attempt *(please specify date)*: _____

Rate member's level of psychological distress: ○ 1 *(minimal)* ○ 2 *(mild)* ○ 3* *(moderate)* ○ 4* *(marked)* ○ 5* *(severe)*

Current risk of psychiatric hospitalization*: ○ 1 *(minimal)* ○ 2 *(mild)* ○ 3* *(moderate)* ○ 4* *(marked)* ○ 5* *(severe)*

***If 3 or higher, have you created/reviewed a crisis plan for this member?** ○ Yes* ○ No ○ Member declined

***If yes does member have a copy?** ○ Yes ○ No

Has the member been in higher level of care in the last 12 months? ○ Yes ○ No

Was a standard instrument used to evaluate treatment progress? ○ Yes* ○ No ***If yes, name instrument(s):** _____

W-9 Forms are required for Out-of-Network Providers. Failure to provide the required W-9 Form may result in claim denial.
Please ***fax*** the required W-9 Form to Carelon Behavioral Health at **866-612-7795**.