Empire BlueCross BlueShield

An Anthem Company

Mental Health and Substance Use Nonacute Services (Outpatient Treatment) Request Form

Fill out completely to avoid delays. Once complete, submit via our website at **www.empireblue.com/nymedicaiddoc** or fax to **1-866-877-5229**.

Identifying data		
Patient's name:		
Medicaid ID:	DOB:	
Patient's address:		
City, State ZIP code:		
Provider information		
Provider name:		
Tax ID:		
Phone:	Fax:	
PCP name:	PCP NPI:	
Name of other behavioral health providers:		
ICD-10 diagnoses		
Medications (Please indicate changes since last report.)		
Current medications:	Dosage:	Frequency:
Current risk factors		
Suicide:	☐ None ☐ Ideation ☐Intent without means ☐Intent with means ☐Contracted not to harm self	
Homicide:	☐ None ☐ Ideation ☐Intent without means ☐ Intent with means ☐ Contracted not to harm others	
Physical or sexual abuse or child/elder neglect:	☐ Yes ☐ No	
	If yes, patient is: ☐ Victim ☐ Perpetrator ☐ Both ☐ Neither, but abuse exists in the family	
	Abuse or neglect involves a child or elder: ☐ Yes ☐ No	
	Abuse has been legally reported: ☐ Yes ☐ No	

NYEPEC-1997-19 December 2019

Symptoms (Include those that are the focus of current treatment.)
Progress since last review
Functional impairments/strengths (For example, note interpersonal relations, personal hygiene, work/school, etc.)
Recovery environment (Please describe support system and level of stress.)
Engagement/level of active participation in treatment
Housing

Co-occurring medical/physical illness
Family history of mental illness or substance abuse

Requested service authorization				
Procedure code:	Number of units:	Frequency:	Requested start date:	Estimated number of units to complete treatment:
Treatment goals				
Goal:			Type of service:	Expected achieve date:
1.				
2.				
3.				
4.				
5.				
Objective outcome criteria by which goal achievement is measured				
1.				
2.				
3.				
4.				

Discharge plan and estimated discharge date

Expected outcome and prognosis
☐ Return to normal functioning ☐ Expect improvement, anticipate less than normal functioning ☐ Relieve acute symptoms, return to baseline functioning ☐ Maintain current status, prevent deterioration
• Please attach summary sheets of any applicable assessments. • Psychological/neuropsychological testing requests require a separate form.

Treatment plan coordination	
I have requested permission from the member/member's parent or guardian to release information to the PCP/psychiatrist.	☐ Yes ☐ No If no, rationale why this is inappropriate:
Treatment plan was discussed with and agreed upon by the member/member's parent or guardian.	☐ Yes ☐ No
Provider's signature:	
Date:	