Behavioral Health Community Based Outpatient Services Request Form

Submit completed form electronically using our preferred method at **Availity** or by fax to **1-833-974-0059**.

Today's date:	
Contact at provider's office:	Secure fax:
Name of requestor:	Phone:
Note: Please provide appropriate contact information, including best working phone number for Humana staff to contact you if we need clarification or additional information to complete the request.	

Member information

Last name:	First name:	
Humana ID:	Medicaid ID:	Date of birth:
Parent/guardian name:		Phone:
Is the member currently in coordinated system of care (CSoC)? ☐ Yes ☐ No		
Authorization reference number (if applicable):		

Requesting provider/facility

Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Treating/servicing provider

Provider name:	TIN:	NPI:
Address:	City, state, ZIP:	
Contact name:	Phone:	Fax:

Services

- ☐ Community psychiatric support and treatment (CPST)
- ☐ Psychosocial rehabilitation (PSR)
- ☐ Home Builders (HB)
- ☐ Multisystemic therapy (MST)
- ☐ Functional Family Therapy (FFT)
- ☐ Assertive Community Treatment (ACT)
- ☐ Other: _____

Humana
Healthy Horizons®
in Louisiana

Diagnosis code(s) and date(s) of service (DOS)			
ICD-10*:	ICD-10*:	ICD-10*:	ICD-10*:
Start date of service:		End date of service:	
Type of request: ☐ Initial request ☐ Concurrent request			

* ICD-10 codes are from the International Classification of Diseases, Tenth Edition.

Service code(s) including modifiers as indicated			
Code:	Units:	Frequency:	Total units requested:
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Code:	Units:	Frequency:	Total units requested:
Code:	Units:	Frequency:	Total units requested:

Diagnosis (psychiatric, chemical dependency and medical)

Current behavioral health services and providers

Previous behavioral health services and providers

Risk of harm to self (within the past 24 to 48 hours)

If present, describe:

If prior attempt, date and description:

Risk rating (select all that apply)

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Risk of harm to others (within the past 24 to 48 hours)

If present, describe:

If prior attempt, date and description:

Risk rating (select all that apply)

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt

Medications—please list current and previous

Is member compliant with medications? ☐ Yes ☐ No

Assessments—please attach to request

Level of Care Utilization System (LOCUS) or Child/Adolescent Level of Care Utilization System (CALOCUS) date: _____

Licensed mental health professional (LMHP) name: _____

Treatment plan: Indicate the service (e.g., CPST or PSR) and interventions, the duration and frequency for each and the time needed to complete them.

Goal	
Service	
Type of intervention	
Duration and frequency	
Length of intervention	
Who will provide intervention?	

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If requesting to provide both CPST and PSR, please explain the need for both services and how they will differ in delivery.

Has the member displayed any of the following within the past month?

- ☐ Angry outburst/aggression
- ☐ Arrest/confirmed illegal activity
- ☐ Substance use disorder (SUD)
- ☐ Lack of motivation for SUD treatment
- ☐ Delusions/hallucinations
- ☐ Destruction of property
- ☐ Disorganized thoughts, speech or behavior
- ☐ Difficulty with activities of daily living (ADLs) such as cooking, bathing, financial management, etc.
- ☐ Inability to utilize or absence of formal or informal supports
- ☐ Hypomanic or hypermanic symptoms
- ☐ Nonsuicidal self-injury
- ☐ Obsessions or compulsions
- ☐ Repeated acute psychiatric hospitalizations
- ☐ Psychiatric medication noncompliance
- ☐ Sexually abusive/threatening behavior
- ☐ Suicidal ideations

Have any of these behaviors persisted for at least 6 months? ☐ Yes ☐ No

If **yes**, please explain:

Has the member had unsuccessful treatment or lack of improvement in any of the following within the past month?

- ☐ Group home
- ☐ Mental health rehabilitation services (CPST, PSR, HB, FFT, MST)
- ☐ SUD treatment
- ☐ Outpatient therapy services
- ☐ Psychiatric inpatient services
- ☐ Residential treatment
- ☐ Therapeutic group home

Please describe the member's support system:

The member displays severe impairment in the following areas:

- ☐ ADLs
- ☐ Community living
- ☐ Family relationships
- ☐ Work performance
- ☐ Social relationships

For continued stay requests, please complete the following:

Within the past month, has the member experienced and/or displayed the following:

- ☐ After-hours crises
- ☐ Anger outbursts
- ☐ Arrests
- ☐ Depressed mood
- ☐ Destruction of property
- ☐ Distractibility
- ☐ Homicidal ideations
- ☐ Hypomanic symptoms
- ☐ Isolation
- ☐ Job or daily structure activities interrupted
- ☐ Manipulative behavior
- ☐ Neglect of ADLs
- ☐ Obsessions/compulsions
- ☐ Physical altercations
- ☐ Poor boundaries
- ☐ Post-traumatic stress disorder or trauma
- ☐ Psychiatric medication noncompliance
- ☐ Psychosis
- ☐ Serious rule violations
- ☐ Stalking
- ☐ SUD with high risk of relapse
- ☐ Suicidal ideations
- ☐ Theft
- ☐ Other: _____

Please describe progress, improvement and/or lack of, since beginning current service.

Please indicate why a lower level of care would not be appropriate at this time.

Please indicate discharge plan for member, including anticipated time frames and follow-up services.

Please provide any additional clinical information to support the medical necessity of the requested services.

Submitted by:	**Date:**