AmeriHealth Caritas
VIP Care

# Behavioral Health Outpatient Treatment Request Form

When complete, please fax to **1-833-329-3586**.

**Please type or print clearly. Incomplete and illegible forms will delay processing.**

Prior authorization is required for outpatient services. For psychological and neurological testing, please submit the Testing Outpatient Request Form.

**Electroconvulsive therapy (ECT) services must have prior authorization by telephonic review. Please call 1-833-435-8686.**

**Out-of-network providers:** Prior authorization and a non-contracted provider form are required for all services.

## Member information

| | |
|---|---|
| Member name: | Member ID number: |
| Social Security number: | Date of birth: |
| Member address: | |
| City, state, ZIP code: | Phone: |
| Who referred member for treatment? ☐ Self ☐ Primary care provider (PCP) ☐ State agency ☐ Other:_____ | |
| Name of referring agency: | Phone: |

## Treating provider information

| | |
|---|---|
| Name (with credentials): | ☐ NPI : _____ ☐ In network ☐ Out of network ☐ In credentialing process |
| Phone: | Fax: |
| Address: | City, state, ZIP code: |
| Group name/number: | Contact name: |
| Treating provider signature: | |

## Reason for services

| | |
|---|---|
| Primary reason or complaint: | Start date requested: |
| Service codes requested: | Frequency: |

## DSM diagnosis

List all Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses (behavioral health and medical).

## Supports and care coordination

1. Is the member currently participating in any vocational services? ☐ Yes ☐ No
2. Is the member's family or supports involved in treatment? ☐ Yes ☐ No
3. Has the member been evaluated by a psychiatrist? ☐ Yes ☐ No
4. Is there coordination with other substance use providers? ☐ Yes ☐ No
5. Is there coordination of care with other behavioral health providers? ☐ Yes ☐ No
6. Is there coordination of care with medical providers? ☐ Yes ☐ No

## Medications

| | |
|---|---|
| Is member on prescribed medication? ☐ Yes ☐ No | Is member compliant with medication? ☐ Yes ☐ No |
| Prescribing providers: | |
| Medications and dosages: | |

**Please attach the current treatment plan.** Include documentation related to progress on goals and any changes made as a result.

## Additional comments