Out of Network Outpatient Treatment Review (OTR) Form*

NOTE: This form cannot be used to request ECT, neuropsychological or psychological testing. Please call 313-344-9035 for these services.

MEMBER INFORMATION

Name: _____ Date of Birth: _____Medicare Id#_____ Medicaid ID# _____

PROVIDER INFORMATION

(For non-participating/non contracted providers)

Provider Organization: _____ **DWMHA Contract ID #: _____(if known)
Provider Organization Address: _____City, State, Zip Code: _____Tel. #: _____ Fax #:_____
NPI # of Provider: _____ Tax ID # of Provider: _____
Location of Services provided (if different from above:
City, State, Zip Code: _____
Tel. #: _____ Fax #:_____NPI # of Provider: _____ Tax ID # of Provider: _____
Name of Individual Provider rendering services: _____ Professional Licensure/Credentials: _____
Name of Individual Provider rendering services: _____ Professional Licensure/Credentials: _____

DIAGNOSTIC INFORMATION

Type of Service Requested: ☐ Mental Health ☐ Substance Abuse ☐ Intellectual Development Disability
Behavioral DX (DSM 5 code and description, its successor or ICD 10):
Axis I (include All): _____/_____ Axis II: _____/_____Axis III _____Axis IV: _____GAF: Current: _____ Highest in past 12 months ___
Medical Condition or Diagnosis 1. _____/_____ 2._____/_____ 3._____/_____
Summary: _____
_____
_____

TREATMENT HISTORY: *(Please check all that apply)*

Previous Treatment in the Past 12 months, excluding current course of treatment ☐ Mental Health ☐ Substance Abuse ☐ Both ☐ None ☐ Unknown
Treatment Level: ☐ Outpatient ☐ Partial/IOP ☐ Inpatient ☐ Residential ☐ Other_____
Locus Score (if applicable): _____ Date of LOCUS Assessment: _____
SIS Score (if applicable): _____ Date of SIS Assessment: _____
Outcome: ☐ Unknown ☐ Improved ☐ No Change ☐ Worse *Treatment Compliance (non-medical):* ☐ Unknown ☐ Poor ☐ Fair ☐ Good

CURRENT RISK ASSESSMENT: *(Please check value for each type of risk)*

Risk to Self: ☐ None ☐ Mild, ideations only ☐ Moderate, ideations w/EITHER plan or history of attempts ☐ Severe, ideations AND plan, w/either intent or means ☐ Not Assessed
Risk to Others: ☐ None ☐ Mild, ideations only ☐ Moderate, ideations w/EITHER plan or history of attempts ☐ Severe, ideations AND plan, w/either intent or means ☐ Not Assessed
Does the member have a behavioral health crisis management or safety plan? ☐ No ☐ Unknown ☐ Yes (Please provide date of plan): _____

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CURRENT IMPAIRMENTS: (Please circle one value for each)

Scale: 0=none 1=mild/mildly incapacitating 2=moderate/moderately incapacitating 3=severe/severely incapacitating NA=not assessed

Mood Disturbance (Depressions or Mania)	0 1 2 3 N/A	Anxiety	0 1 2 3 N/A
Psychosis/Hallucinate/ Delusions	0 1 2 3 N/A	Thinking/Cognition/Memory, Concentration Problems	0 1 2 3 N/A
Impulsive/Reckless/Aggressive Behavior	0 1 2 3 N/A	Activities of Daily Living Problems	0 1 2 3 N/A
Sleep Disturbance	0 1 2 3 N/A	Lack of Motivation/Pleasure	0 1 2 3 N/A
Weight Change associated w/ Behavioral Diagnosis	0 1 2 3 N/A	Select One: ☐ Gain ☐ Loss of ___ pounds in the past 3 months	☐ N/A
Substance Abuse/Dependence	0 1 2 3 N/A	Job/School Performance Problems	0 1 2 3 N/A
Social Relationship/Martial/Family Problems	0 1 2 3 N/A	Legal Problems	0 1 2 3 N/A
Other (describe) _____	0 1 2 3 N/A		

MEDICATIONS

***0=non-compliant 1=occasional use 2=uses most days 3=taken as prescribed*

Medication Name	Dose & Frequency	Name of Prescriber	Purpose	Start Date	End Date *(if applicable)*	Compliance Rating ***See Above*

TREATMENT GOALS

☐ Behavioral/Cognitive Change ☐ Mood/Affect Change ☐ Environmental/Relationship Change ☐ Insight into Problems ☐ Other (specify)_____

TREATMENT HISTORY & REQUEST FOR AUTHORIZATION

DWMHA Initial Date of Service (In-Take): _____ Start Date: _____ End Date:_____

CPT Code(s) Requested & Frequency of Each CPT Code: 1) _____/ _____ 2) _____/ _____ 3)_____/ _____

CARE COORDINATION

Mental Health ☐Yes ☐No ☐ N/A Substance Use Disorder ☐ Yes ☐ No ☐N/A Physical Health ☐ Yes ☐ No ☐N/A

Is treatment being coordinated with PCP? ☐ Yes Name of PCP: _____ Address: _____

☐ No If no please give reason: _____

***For Out-Patient Eating Disorders**:* Please provide documentation the treatment plan includes:

☐ Monitoring of target weight ☐ Rate of progress ☐ Member is receiving nutritional counseling by a trained Affiliated Provider

Treating Affiliated Provider's Signature with credentials:_____ Date: _____

**The above signature shall serve as an attestation that the information provided is accurate to best of provider's knowledge; and services will be rendered as described above.*

Provider Contact Name:_____ Department : _____ Phone # of Provider Contact: _____

For internal purposes only:

Date of receipt: _____ Logged by: _____

Request for additional information:

☐ Clinical: _____ Date of request _____ Date of Receipt: _____

☐ Administrative: _____ Date of request _____ Date of Receipt: _____

Please fax the completed OTR to (313)833-3670. Questions or concerns please feel free to contact UM – Clinical Specialist at (313)344-9035.