

Network Health Plan Outpatient Treatment Request for Behavioral Health Services-Concurrent

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.
 Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha, WI 54952
 Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name:		Date of Birth:		Age:	
Therapist Name:		Facility:			
Phone Number:		Fax Number:			
Requesting	additional sessions	Axis I Diagnosis:			
Requested auth start date:					

Behavior/Symptoms: Check all that apply within the last month:

- | | |
|--|--|
| <input type="checkbox"/> Suicidal/Homicidal Ideation | <input type="checkbox"/> Active substance use/medication misuse |
| <input type="checkbox"/> Psychosis | <input type="checkbox"/> Loss of interest/anhedonia |
| <input type="checkbox"/> Unwilling/Unable to follow medication regimen | <input type="checkbox"/> Disordered eating |
| <input type="checkbox"/> Weight loss/weight gain | <input type="checkbox"/> Fatigue/loss of energy |
| <input type="checkbox"/> Sleep disturbance/insomnia | <input type="checkbox"/> Angry outbursts/irritability |
| <input type="checkbox"/> Self-injurious behavior | <input type="checkbox"/> Impulsive/agitated behaviors (list symptoms) |
| <input type="checkbox"/> Reckless/high risk behaviors (list symptoms) | <input type="checkbox"/> Child/Adolescent disruptive behaviors (list symptoms) |
| <input type="checkbox"/> Anxiety (list symptoms) | <input type="checkbox"/> Elevated/Expansive mood (list symptoms) |
| <input type="checkbox"/> Co-morbid medical condition(s) | <input type="checkbox"/> Depressed mood (list symptoms) |
| <input type="checkbox"/> Difficulty concentrating/making decisions | <input type="checkbox"/> Feelings of hopelessness or worthlessness |
| <input type="checkbox"/> Other _____ | |

Functional Impairment: Check all that apply within the last month:

- | | |
|--|---|
| <input type="checkbox"/> Stabilized on psychotropic medication regimen | <input type="checkbox"/> Decrease in ability to care for self or others |
| <input type="checkbox"/> Decrease in social contact/social avoidance | <input type="checkbox"/> Absences from school/work |
| <input type="checkbox"/> Change in productivity at school or work | <input type="checkbox"/> Suspensions/Detentions |
| <input type="checkbox"/> LOA due to psych condition | <input type="checkbox"/> Easily frustrated |
| <input type="checkbox"/> Conflictual/hostile relationships | <input type="checkbox"/> Poor/intrusive boundaries |
| <input type="checkbox"/> Responds to limits with difficulty | <input type="checkbox"/> Occasional arguments/verbal hostility |
| <input type="checkbox"/> Other _____ | |

Attendance: >= 80% over past five scheduled visits Yes No Session frequency: _____ x a month
 Individual Group Family Medication Management with MD/APNP

Support : Unavailable Involved in community support group Family/friends involved, supportive

Treatment Goals: (Current and measurable)

Signature: _____ **Date:** _____

For NHP Use:
 Authorization #: _____ additional sessions authorized from _____ until _____
 NHP Staff Signature: _____