TUFTS Health Plan

Tufts Health RITogether
Behavioral Health Outpatient Psychotherapy Authorization Form
Please fax form to: 857.304.6404

Today's date: _____/_____/_____

Behavioral health outpatient psychotherapy requires prior authorization after 12 visits per member per benefit year. To ensure a timely response to your request, please submit this completed form to 1-3 weeks prior to the member's last covered visit. Submission of this form does not guarantee authorization of your request.

Member information

Name: _____
ID #: _____ DOB: _____/_____/_____

Provider information

Name: _____
Agency name: _____ NPI #: _____
Provider address: _____
City: _____ State: _____ Zip: _____
Contact name: _____
Contact phone #: _____ EXT: _____
Length of time member has been in treatment with this provider:
_____/_____/_____ to _____/_____/_____

Agency/group involvement

- ☐ AA/NA
- ☐ Court
- ☐ BHDD
- ☐ DCY
- ☐ DHHS
- ☐ EAP
- ☐ EOHHS
- ☐ Family/Friends
- ☐ Religious groups
- ☐ Spouse/Partner
- ☐ Other: _____

Diagnosis, *please reference ICD-10/DSM codes*

Primary Diagnosis _____
Secondary Diagnosis _____
Relevant Active Medical Diagnoses _____
_____
_____
_____

Requested services

Please complete this table to indicate your current request for the next 3 months' sessions using Current Procedural Terminology (CPT) codes and appropriate modifiers (if applicable).

Date range of requested sessions from: _____/_____/_____ to _____/_____/_____

Code	Sessions	# of sessions requested
90791	Psychiatric diagnosis evaluation (no medical services)	
90832	Individual psychotherapy, 20-30 mins	
90834	Individual psychotherapy, 45 mins	
90846	Family psychotherapy without patient present	
90847	Family psychotherapy with patient present	
90849	Multifamily group therapy	

Forms available at tuftshealthplan.com/provider
Tufts Health Public Plans Rhode Island provider services number: 844.301.4093
6026 06127

Current medications and treatment:

1. Please list current psychotic medications and dosages, if applicable:

_____
_____

2. Please indicate the other providers involved in the member's care.

☐ Group therapist ☐ PCP ☐ Psychiatrist ☐ Specialist ☐ Therapist

☐ HBTS provider ☐ IHH/ACT

3. If the patient is younger than 18, describe how the parent/guardian is involved in treatment.

_____
_____
_____
_____

Assessment

1. Has the member received a higher level of care in the last year? (inpatient, intermediate, residential?)

☐ Yes ☐ No *If yes, specify level of care, number and date(s) of admission(s)*:

_____
_____
_____

2. Please indicate risk of psychiatric hospitalization:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high) *If, 3, 4, or 5 please explain:*

_____
_____
_____

3. Please select **ONE** symptom that best applies to the member:

☐ Anxiety ☐ Disruptive behavior ☐ Mania or hypomania ☐ Reckless or impulsivity

☐ Depression or irritability ☐ Eating disorder ☐ Psychosis ☐ Substance use

Please provide details for the selected symptom. For substance use, please specify the substance used, amount, frequency, duration, and intensity of cravings.

_____
_____

4. Please indicate member's functioning level over the course of the last 5 visits. *Check all that apply.*

☐ Decreased productivity at school or work ☐ Warning/suspension at school or work

☐ Decreased social contact ☐ Subject of complaints registered with the authorities

- ☐ Increased school detention or lower grades
- ☐ School or work absence of at least 2 days per month due to psychiatric symptoms
- ☐ Difficulty respecting limits set by others
- ☐ Leave of absence due to psychiatric disorder
- ☐ Difficulty caring for dependents
- ☐ Stabilized on medication
- ☐ Difficulty with activities of daily living
- ☐ Argumentative or verbally hostile
- ☐ Easily frustrated
- ☐ Other: _____

5. Which of the following behaviors has the member exhibited in the past 3 months? *Check all that apply.*

☐ Family violence ☐ Fire setting ☐ Physical/sexual assault

☐ Coping with loss ☐ Self-mutilation

For self-mutilation please specify frequency and severity: _____

6. Homicide

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt and date: _____/_____/_____

7. Suicide

☐ Not present ☐ Ideation ☐ Plan ☐ Means ☐ Prior attempt and date: _____/_____/_____

8. Has the member attended at least 4 (3, if adolescent) of their last 5 sessions?

☐ Yes ☐ No *If no, please indicate why*: _____

9. Has the member's symptoms improved with treatment?

Behavioral symptoms ☐ Much worse ☐ Worse ☐ No change ☐ Better ☐ Much better

Ability to perform major activities ☐ Much worse ☐ Worse ☐ No change ☐ Better ☐ Much better

If requesting weekly therapy, please describe the steps that will allow your patient to transition to biweekly or monthly sessions: _____
_____

Goals *Please tell us about the member's most significant goals since beginning of treatment*

Goal	Progress Achieved	Barriers to progress

Additional comments or information: _____
_____
_____