

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date _____

Carrier or Appropriate Recipient:

PATIENT INFORMATION

PATIENT'S FIRST NAME PATIENT'S DATE OF BIRTH

_____/_____/____

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID PHONE NUMBER

_____/_____

PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE

Date Patient First Seen For This Episode Of Treatment ____/____/____

Level of care being requested: Please specify benefit type:

- ☐ Mental Health ☐ Substance Use Disorder ☐ Outpatient ☐ Intensive Outpatient Program ☐ Partial Hospitalization Program
☐ Acute IP ☐ IP Rehab ☐ Acute IP Detox ☐ Residential ☐ ECT ☐ rTMS ☐ Applied Behavior Analysis (ABA) ☐ Psychological
Testing ☐ BioFeedback ☐ Telehealth ☐ Other _____

Primary Dx Code: _____

Secondary Dx Code(s): _____

Current Treatment Modalities: (check all that apply)

- Psychotherapy:** ☐ Behavioral ☐ CBT ☐ DBT ☐ Exposure ☐ Supportive Therapy ☐ Problem Focused ☐ Interpersonal
☐ Psychodynamic ☐ EMDR ☐ Group ☐ Couples ☐ Family ☐ Other _____
Medical Evaluation and Management

Type of Medications(if not applicable, no response is required):

- ☐ Antipsychotic ☐ Anxiolytic ☐ Antidepressant ☐ Stimulant ☐ Injectables ☐ Hypnotic ☐ Non-psychotropic ☐ Mood Stabilizer
☐ Other _____

Current Symptoms and Functional Impairments: Rate the patient's current status on these symptoms/functional impairments, if applicable.

	Current Ideation	Current Plan	Prior Attempt	None
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Homicidal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitated/aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social/ Familial/School/Work Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ADL Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If requesting additional outpatient care for a patient, why does the patient require further outpatient care: ☐ Maintenance treatment for a chronic condition ☐ Consolidate treatment gains ☐ Continued impairment in functioning ☐ Significant regression ☐ New symptoms and/or impairments ☐ Supportive treatment due to other treatment plan changes ☐ complex psychiatric and medical co-morbidity ☐ Complex Psychiatric and Substance abuse Co-morbidity
☐ other _____

Signature of Practitioner: _____

Date: ____/____/____

My signature attests that I have a current valid license in the state to provide the requested services.

Patient Membership Number _____

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Complete the following if the request is for ECT or rTMS: Provide clinical rationale including medical suitability and history of failed treatments:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following for Applied Behavior Analysis (ABA) Requests (if the carrier classifies ABA as a mental health benefit):

Supervising BCBA Name _____ Has Autism Spectrum Disorder been validated by MD/DO or Psychologist? Yes No

For initial requests, what are specific ABA treatment goals for the patient?

1. _____
2. _____
3. _____

Date of Evaluation by MD/DO: _____

For continuing requests, assessment of functioning (observed via FBA, ABLLS, VB-MAPP, etc.) related to ASD including progress over the last year:

For continuing requests what are the treatment goals and targeted behaviors, indicating new or continued, with documentation of progress and child's response to treatment:

1. _____
2. _____
3. _____

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Psychological Testing:

Symptoms/Impairment related to need for testing:

- | | |
|---|--|
| <input type="checkbox"/> Acute change in functioning from the individual's previous level | <input type="checkbox"/> Personality problems |
| <input type="checkbox"/> Peculiar behaviors and/or thought process | <input type="checkbox"/> School problems |
| <input type="checkbox"/> Symptoms of psychosis | <input type="checkbox"/> Family issues |
| <input type="checkbox"/> Attention problems | <input type="checkbox"/> Cognitive impairment |
| <input type="checkbox"/> Development delay | <input type="checkbox"/> Mood Related Issues |
| <input type="checkbox"/> Learning difficulties | <input type="checkbox"/> Neurological difficulties |
| <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Physical/medical signs |
| <input type="checkbox"/> Relationship issues | |
| <input type="checkbox"/> Other: _____ | |

Purpose of Psychological Testing:

- ☐ Differential diagnostic clarification
- ☐ Help formulate/reformulate effective treatment plan.
- ☐ Therapeutic response is significantly different from that expected based on the treatment plan.
- ☐ Evaluation of functional ability to participate in health care treatment.
- ☐ Other: (describe) _____

Substance use in last 30 days: ☐ Yes ☐ No Diagnostic Assessment Completed: ☐ Yes Date ____/____/____ ☐ No

Patient substance free for last ten days ☐ Yes ☐ No

Has the patient had known prior testing of this type within the past 12 months? ☐ Yes ☐ No

If so, why necessary now? ☐ Unexpected change in symptoms ☐ Evaluate response to treatment ☐ Assess functioning ☐ Other

Names and Number of Hours of each requested test _____

If appropriate, complete this section: Reason(s) why assessment will require more time relative to test standardization samples?

<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Vegetative Symptom	<input type="checkbox"/> Processing speed	<input type="checkbox"/> Performance Anxiety	<input type="checkbox"/> Expressive/Receptive Communication Difficulties
<input type="checkbox"/> Low frustration tolerance	<input type="checkbox"/> Suspected or Confirmed grapho-motor deficits	<input type="checkbox"/> Physical Symptoms or Conditions such as: _____	<input type="checkbox"/> Other: _____ _____ _____	

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Biofeedback:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Telehealth:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Primary reason for request or admission: (check one) ☐ Self/Other Lethality Issues ☐ Violent, unpredictable/uncontrolled behavior
☐ Safety issues ☐ Eating Disorder ☐ Detox/withdrawal symptoms ☐ Substance Use ☐ Psychosis ☐ Mania ☐ Depression
☐ Other

Medication adjustments (medication name and dose) during level of care: _____

Prior Treatment in past 6 months:

Support System/Home Environment: _____

Treatment Plan (include objectives, goals and interventions): _____

If Concurrent Review—What progress has been made since the last review _____

Why does member continue to need level of care _____

Discharge Plan (including anticipated discharge date)_____

	Low	Medium	High
1. Acute intoxication and/or withdrawal potential			
2. Biomedical conditions and complications			
3. Emotional, behavioral, or cognitive conditions and complications			
4. Readiness to charge			
5. Relapse, continued use, or continued problem potential			
6. Recovery/living environment			

[illegible]

Complete the following if substance use is present for higher level of care requests:

Type of substance use disorder _____
Onset: Recent Past 12 Months More than 12 months ago
Frequency: Daily Few Times Per Week Few Times Per Month Binge Pattern
Last Used: Past Week Past Month Past 3 Months Past Year More than one year ago
Consequences of relapse: Medical Social Housing Work/School Legal Other _____ Urine Drug
Screen: Yes No Vital Signs: _____ Current
Withdrawal Score: (CIWA _____ COWS _____) or Symptoms (check if not applicable) _____

History of: Seizures DT's Blackouts Other Not Applicable

Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:

Height: _____ Weight: _____ % of NBW _____
Highest weight _____ Lowest weight _____ Weight change over time (e.g. lbs lost in 1 month) _____
If purging, type and frequency _____ Potassium _____ Sodium _____ Vital signs _____
Abnormal EKG _____ Medical Evaluation ☐ Yes ☐ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues: _____

Please include any current medical/physiological pathologic manifestations: _____

