Companion
BENEFIT ALTERNATIVES

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www.CompanionBenefitAlternatives.com

Outpatient Substance Use Disorder Treatment Request

Do NOT use this form for IOP/PHP SUD treatment requests. Call CBA or visit our website to precertify IOP/PHP treatment.

Use this form only to request group or individual therapy for substance use disorders.
For any mental health treatment requests, use the Outpatient Mental Health Treatment Request form.

**Required information*

Please indicate if this is* ☐ an Initial Review or ☐ a Continued Review.

Clinician's First Name*: ______________________________
Clinician's Last Name: ______________________________
Licensure*: ______________________________
Phone*: ______________________________
Fax*: ______________________________
E-mail: ______________________________
Mailing Address 1*: ______________________________
Mailing Address 2: ______________________________
City*: ______________________________
State*: ______________ ZIP Code*: ____________
Clinician's NPI*: ______________________________
Group NPI: ______________________________

Facility's Name: ______________________________
Facility's Phone: ______________________________
Facility's NPI: ______________________________

Patient's First Name*: ______________________________
Patient's Last Name*: ______________________________
Date of Birth*: ______________________________
ID Card Number*: ______________________________
Phone: ______________________________
E-mail: ______________________________

Diagnosis:

Axis I*	________________
Axis II	________________
Axis III	________________
Axis IV	________________
Axis V	Initial GAF*: _________
	Current GAF*: ________

CPT Code Information:

CPT Code 1*	____________	Frequency*	__________	time(s) per	☐ week	☐ month
CPT Code 2	____________	Frequency	__________	time(s) per	☐ week	☐ month
CPT Code 3	____________	Frequency	__________	time(s) per	☐ week	☐ month

If requesting CPT code 90847, is the service for ☐ marriage therapy or ☐ family therapy?

If diagnosis is related to eating disorders, answer the following:
Current Height: _________ Current Weight: ____________ Weight Loss/Gain: ☐ Loss ☐ Gain
Weight Loss/Gain: __________ lbs Weight Loss/Gain occurred in last _____________ months.

Treatment Start Date*: ________________________ **Certification Start Date*:** __________________________

Please complete the section below for all requests:

Impairments	None	Mild	Moderate	Severe	Duration of Symptoms
Coping Abilities*	☐	☐	☐	☐	☐ Less than 1 month ☐ 7–11 months ☐ 1–6 months ☐ More than 1 year
Direct Health Harms*	☐	☐	☐	☐	☐ Less than 1 month ☐ 7–11 months ☐ 1–6 months ☐ More than 1 year

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Legal*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Marriage/Family*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Medical Comorbidities*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Work/School Performance*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year

Substance(s) Used/Using?

Substance(s)*	Age at Onset*	Frequency of Use*	Amount Used*	Duration of Current Episode*	Last Use or Relapses*	UDS/BAL*

Has the patient ever received prior treatment?* ☐ **Yes** ☐ **No** ☐ **Unsure**
If yes, answer the following:

Prior Treatment Information:

Date of Service	Facility's Name	Level of Care	Duration of Sobriety
		☐ Inpatient ☐ Outpatient ☐ IOP/PHP ☐ RTC	
		☐ Inpatient ☐ Outpatient ☐ IOP/PHP ☐ RTC	
		☐ Inpatient ☐ Outpatient ☐ IOP/PHP ☐ RTC	

Has the patient reported prior relapses?* ☐ **Yes** ☐ **No**
If yes, answer the following:

Document Any Relapses:

Date	Substance	Self-Report	UDS Results	Breathalyzer Results
		☐ Yes ☐ No		

Is the patient currently taking any anti-craving or psychotropic medication?* ☐ **Yes** ☐ **No**
If yes, answer the following:

Medication Name	Dose	Start Date

Document Family Sessions and Results:

Session/Result*	Date

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For Continued Stay Request only, please indicate the appropriate level of participation for each category below:

Level of Individual Participation*	☐ None	☐ Minimal	☐ Moderate	☐ Active
Level of Family Participation*	☐ None	☐ Minimal	☐ Moderate	☐ Active
Outside AA/NA Attendance*	☐ None	☐ 1–4/Week	☐ > 4/Week	
Sponsorship*	☐ Nome	☐ Temporary	☐ Permanent	

Skill Development:	No Progress	Minimal Progress	Average Progress	Good Progress
Relapse Prevention*	☐	☐	☐	☐
Craving Management*	☐	☐	☐	☐
High-Risk Situations*	☐	☐	☐	☐

Treatment Goals* (Please list the three most significant problems you have identified): **Estimated Completion Date*:**

1. ______________________________ ______________
2. ______________________________ ______________
3. ______________________________ ______________

Patient's Response/Progress on Treatment Goals*:

____
____
____
____

Specify Support System*:

____
____
____
____

Certification is not valid until CBA issues certification number.

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