Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
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www.CompanionBenefitAlternatives.com

Continued Outpatient Mental Health Treatment Request

**Required information*

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: _____

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

Diagnosis
Axis I*: _____ Axis V: Initial GAF*: _____
_____ Current GAF*: _____
Axis II: _____
Axis III: _____
Axis IV: _____ Treatment Start Date*:
_____ _____

Harm Issues*: ☐ None ☐ Self ☐ Others

Please check all that apply*:
☐ Thoughts of passively dying
☐ Active thoughts
☐ Endorses intent
☐ Endorses plan

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 in last _____ months:

Impairments:	**None**	**Mild**	**Moderate**	**Severe**	**Duration of Symptoms**
Appearance/Grooming/Dress*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months ☐ 7–11 months ☐ More than 1 year
Hallucinations/Delusions*	☐	☐	☐	☐	☐ 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
Sleep Disturbances*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months ☐ 7–11 months ☐ More than 1 year
Social/Recreational*	☐	☐	☐	☐	☐ 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

Is there co-morbid substance use?* ☐ Yes ☐ No ☐ Unsure
If yes, answer the following:
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____
Substance: _____ Frequency: _____ Amount: _____

Has patient been referred to: ☐ AA ☐ CD Inpatient Treatment ☐ CD Outpatient Treatment

Is the patient currently taking any medication?* ☐ Yes ☐ No ☐ Unsure

If yes, answer the following:

Name	Dose	Frequency	Side Effects	Compliance %

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

1. _____ _____
2. _____ _____
3. _____ _____

List the requested procedure codes*:

CPT Code: _____ Frequency: _____ time(s) per ☐ week ☐ month
CPT Code: _____ Frequency: _____ time(s) per ☐ week ☐ month
CPT Code: _____ Frequency: _____ time(s) per ☐ week ☐ month

Is the service for 90847 for ☐ marriage therapy or ☐ family therapy?
If requesting CPT code 90853, list groups name :

Certification Start Date*: _____

Have you contacted the prescribing and/or referring physician? ☐ Yes ☐ No

Certification is not valid until CBA issues a certification number.