Companion
BENEFIT ALTERNATIVES

Phone: 800-868-1032
Fax: 803-714-6456
www.CompanionBenefitAlternatives.com

Extended 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: _____ Last Office Visit*:
_____ _____

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 occurred in last _____ months

Impairments	None	Mild	Moderate	Severe	Duration of Symptoms
Anxiety/Panic/OCD*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months ☐ 7–11 months ☐ More than 1 year
Appearance/Grooming/Dress*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months ☐ 7–11 months ☐ More than 1 year
Depression/Labile Mood*	☐	☐	☐	☐	☐ 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
Inattention/Hyperactivity*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months ☐ 7–11 months ☐ More than 1 year
Manic Symptoms*	☐	☐	☐	☐	☐ 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
Somatic Complaints*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months ☐ 7–11 months ☐ More than 1 year

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Work/School Performance*	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7–11 months ☐ More than 1 year
Other	☐	☐	☐	☐	☐ Less than 1 month ☐ 1–6 months	☐ 7Ø11 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 %

Reasons for non-compliance: _____

Treatment History	Psychiatric	Substance Use Disorder	Recent Treatment	
Inpatient	☐	☐	☐ Last 90 Days ☐ Last six months	☐ Last 12 months ☐ More than prior 12 months
RTC	☐	☐	☐ Last 90 Days ☐ Last six months	☐ Last 12 months ☐ More than prior 12 months
IOP	☐	☐	☐ Last 90 Days ☐ Last six months	☐ Last 12 months ☐ More than prior 12 months
Partial	☐	☐	☐ Last 90 Days ☐ Last six months	☐ Last 12 months ☐ More than prior 12 months
Outpatient	☐	☐	☐ Last 90 Days ☐ Last six months	☐ Last 12 months ☐ More than prior 12 months

Lifetime Admissions: ☐ None ☐ 1–2 Admissions ☐ More Than 2 Admissions

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

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

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Progress in Treatment*:

- ☐ Continues with/or Reoccurrence of Acute Presenting Symptoms
- ☐ Mild to Moderate Improvement
- ☐ Significant Improvement of Symptoms
- ☐ Needs Support/Maintenance Only
- ☐ Termination Phase of Treatment
- ☐ Other: _____

Expected Treatment Outcomes*: (check all that apply)

- ☐ Discharge from Active Treatment Due to Significant Improvement in Symptoms
- ☐ Discharge from Active Treatment, Transfer to Self-Help/Other Supports
- ☐ Provide Ongoing Supportive Counseling to Maintain Stabilization of Symptoms

List the requested procedure codes*: Please indicate frequency of time frame for each requested CPT code.

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

If requesting CPT code 90847, is the service for ☐ marriage therapy or ☐ family therapy?
If requesting CPT code 90853, list group's name;

Certification Start Date*: _____

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

Additional Clinical Information/Progress Since Last Update:

_____
_____
_____
_____

Certification is not valid until CBA issues a certification number.