

# HEALTHCHOICE

3545 NW 58<sup>th</sup>, Suite 500, Oklahoma City, OK 73112  
Phone: 1-800-543-6044 or 1-405-717-8879  
FAX: 1-405-717-8947 or 1-405-717-8935

## MENTAL HEALTH REQUEST

**This information is private and confidential.**

(◆) Billing Provider: \_\_\_\_\_ (◆) Date: \_\_\_\_\_

(◆) Billing Address: \_\_\_\_\_

(◆) TIN: \_\_\_\_\_ Contact Person : \_\_\_\_\_

Phone: \_\_\_\_\_ (◆) Fax # : \_\_\_\_\_

(◆) Patient: \_\_\_\_\_ (◆) DOB: \_\_\_\_\_

(◆) Member: \_\_\_\_\_ (◆) Member ID #: \_\_\_\_\_

**(◆) DSM IV Diagnosis:**

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV (List Stressors) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Axis V \_\_\_\_\_

\_\_\_\_\_ Highest GAF in the Past Year \_\_\_\_\_

**(◆) HISTORY OF PSYCHIATRIC TREATMENT** – Date(s) and/or number of previous hospitalization, length of time patient has been in Outpatient's Service: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNIFICANT DIAGNOSTIC CHANGES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DESCRIBE** current symptoms that are the primary focus of treatment and Progress in Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS** – Name, dosage frequency and response to medications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT GOALS** – Include time frame to meet goals: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**DESCRIBE** the proposed treatment and why you consider it to be medically necessary at this time: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of Additional Sessions: \_\_\_\_\_ Beginning Date of Additional Sessions: \_\_\_\_\_

Please indicate type(s) of service provided BY YOU, and the frequency:

- |  |                                 |                                  |                                |                                      |
|--|---------------------------------|----------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Medication Management 90862             | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy (20-30 min.) 90804 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy (45-50 min.) 90806 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy w/Med. Mgmt. 90807 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Family Psychotherapy (60-90 min.) 90847 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Group Therapy (60-90 min.)              | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Intensive Outpatient                    | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____                             | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |

**NOTE: EACH REQUEST FOR ADDITIONAL SERVICES REQUIRES A NEW "MENTAL HEALTH REQUEST" FORM.**

\*\*\*\*\*FOR HCMD USE ONLY (Do Not Write Below This Line)\*\*\*\*\*

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** These benefits are applicable only if the patient is eligible for HealthChoice, and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1 (800) 782-5218.

**MEDICARE PATIENTS:** If HealthChoice is supplement, all services requested must initially be approved by Medicare.

**(◆) DENOTES INFORMATION REQUIRED TO COMPLETE REVIEW FOR CERTIFICATION**