

# HEALTHCHOICE

## MENTAL HEALTH REFERRAL

Phone 1-800-543-6044 or 1-405-717-8879

Fax # 1-405-717-8704

This Information is private and confidential.

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

Provider \_\_\_\_\_

Network

Address \_\_\_\_\_

Non-Network

Contact Person \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Patient \_\_\_\_\_

DOB \_\_\_\_\_

Member's Name \_\_\_\_\_

Member's 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** - Dates(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.

\_\_\_\_\_

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**PROGRESS IN TREATMENT** - If condition has shown minimal improvement, list factors that may contribute to the last of improvement.

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**CURRENT MEDICATIONS** - Name, dosage frequency and response to medications.

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**WHAT** community resources have been considered? What community resources are available? EAP involvement?

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**TREATMENT GOALS** - Include time frame to meet goals.

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

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**Number** of Session Requested \_\_\_\_\_ Beginning Date of Additional Sessions \_\_\_\_\_  
With End Date Of \_\_\_\_\_

\_\_\_\_\_  
Signature

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

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

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

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

These benefits are applicable only if the patient is eligible for the Employees Group Insurance Program and are subject to **ALL POLICY PROVISIONS**. Please Remember to verify benefits and eligibility by calling 1-800-782-5218.

**MEDICARE PATIENTS:** If the Employees Group Insurance Program is supplement, all services requested must be approved by Medicare.

**TO ASSURE PAYMENT --- ATTACH REFERRAL TO CLAIM FORM**