HEALTH SERVICES
REVIEW OF TREATMENT

BEHAVIORAL HEALTH TREATMENT PLAN — REQUEST FOR DETERMINATION OF MEDICAL NECESSITY

PATIENT INFORMATION

Name: ________________________________ DOB: ____/____/____ PacificSource ID: __________________

PRACTITIONER INFORMATION

Name: ________________________________ License type: _______________Tax ID Number:____________

Address: ____

City/State: _____________________________ Phone: __________________ Fax: ____________________

TREATMENT INFORMATION

DSM IV: ___________________ **Disorder**: ____
(Please include both DSM IV code and name of disorder)

Medications: ☐ Not considered ☐ Under consideration ☐ Are prescribed

Prescribing clinician: ☐ PCP ☐ PMHNP ☐ Psychiatrist

Are you coordinating care with the prescriber? ☐Yes ☐ No

Date of initial visit for current episode: ____/____/____ Date of last visit: ____/____/____
Total visits to date: ______

Treatment goals (behaviorally defined) and expected outcomes for this request: __________________________

____

____

Progress made in treatment toward these goals: ____

____

____

Termination Criteria—Indicate how termination will occur: ____

____

____

Estimated number of visits until termination: ________

VISITS REQUESTED

Number of additional visits proposed: _____ **Time Frame:** ____/____/____ to ____/____/____

CONTACT INFORMATION

Contact person/clinic/provider: ____

Date: ____/____/____ Phone: _____________________ Fax: _____________________