Behavioral Health Outpatient Clinical Review Form

Use this form when gathering information for outpatient precertification or concurrent review authorization with Author by Humana. Please type or print legibly and complete the entire form before submitting. Circle or check responses where applicable.

For any questions, please contact an Author by Humana Provider Navigator at 1-833-502-2013, from 8 AM to 5 PM Eastern time, Monday through Friday.

Member Information

Member Name: ______________________________

Date of Birth: ____________________ Member ID Number: ____________________

Provider Information

Provider Name: ______________________________

Address: ______________________________

City: ______________ State: ______________ Zip Code: ______________

Phone: ______________ Fax: ______________

Tax ID #: ______________ NPI #: ______________

DSM-V Diagnosis

Please circle the type of service requested: **Mental Health** **Substance Use**

Indicate the primary diagnosis: ______________________________

If applicable, indicate secondary diagnoses: ______________________________

Current Risk Assessment

Please circle the applicable risk assessment for each area below.

Member's risk to self:

No risk **Mild risk** **Moderate risk** **Severe risk** **Not assessed**

Member's risk to others:

No risk **Mild risk** **Moderate risk** **Severe risk** **Not assessed**

Requested Services

Please check the type(s) of services provided and circle the frequency.

	Code	Description	Frequency			
______	90832	Psychotherapy, 30 minutes (16-37 minutes)	Weekly	Bi-weekly	Monthly	Quarterly
______	90834	Psychotherapy, 45 minutes (38-52 minutes)	Weekly	Bi-weekly	Monthly	Quarterly
______	90837	Psychotherapy, 60 minutes (53 minutes and over)	Weekly	Bi-weekly	Monthly	Quarterly
______	90846	Family or couples therapy, without the patient present	Weekly	Bi-weekly	Monthly	Quarterly
______	90847	Family or couples therapy, with the patient present	Weekly	Bi-weekly	Monthly	Quarterly
______	90853	Group psychotherapy (not family) without the patient present	Weekly	Bi-weekly	Monthly	Quarterly
______	______	______________________	Weekly	Bi-weekly	Monthly	Quarterly

Estimated length of treatment: ____________________ Requested number of sessions: __________

author by Humana

Date of last visit: ____________ Requested start date for this certification: ____________

Current Medications *(psychiatric only)*

Medication:	Dose/Frequency:
____________	____________
____________	____________
____________	____________

Medical Conditions

Please check the patient's medical conditions.

____ None ____ Neurological ____ Diabetes ____ COPD ____ Cancer

____ Arthritis ____ Heart Disease ____ Injury ____ Stroke ____ Other: ____________

Treatment Focus Areas

Please circle the applicable assessment for each area below.

Mood Disturbances (Depression or Mania):

None Mild Moderate Severe Not assessed

Anxiety:

None Mild Moderate Severe Not assessed

Psychosis/Hallucinations/Delusions:

None Mild Moderate Severe Not assessed

Thinking/Cognition/Memory/Concentration Problems:

None Mild Moderate Severe Not assessed

Treatment Focus Areas *(continued)*

Impulsive/Reckless/Aggressive Behavior:

None **Mild** **Moderate** **Severe** **Not assessed**

Activities of Daily Living Problems:

None **Mild** **Moderate** **Severe** **Not assessed**

Weight Loss Associated with Eating Disorder:

None **Mild** **Moderate** **Severe** **Not assessed**

Medical/Physical Problems:

None **Mild** **Moderate** **Severe** **Not assessed**

Substance Use/Dependence:

None **Mild** **Moderate** **Severe** **Not assessed**

Job/School Performance Problems:

None **Mild** **Moderate** **Severe** **Not assessed**

Social/Relationships/Marital/Family Problems:

None **Mild** **Moderate** **Severe** **Not assessed**

Legal Problems:

None **Mild** **Moderate** **Severe** **Not assessed**

Treatment Compliance

Is the patient compliant with treatment recommendations? Yes __________ No __________

If no, please explain: ____

Is the patient attending treatment regularly? Yes ________ No ________

Is the patient taking medications as prescribed? Yes ________ No ________

Discharge & Aftercare Plans

What resources are needed to maintain the gains made in treatment?

____

____

____

Are there any unmet psychosocial needs?

____

____

____

With community health outreach and comprehensive discharge planning, Author by Humana is committed to supporting your patient's behavioral health needs. If you would like to be contacted for more information on behavioral health services, please check "yes" below.

Yes ____________ No ____________

Provider's Signature: ______________________________ Date: ____________

Providers will be notified of approval via phone and/or fax. Denial will be provided via fax. Certifications are based on clinical criteria and are not a confirmation of benefit eligibility or guarantee of claim payment. Final determination of claim reimbursement is made at the time the claim is processed. All additional sessions must be pre-certified. If Author by Humana is unable to determine medical necessity based on the information provided on this form, you will be contacted prior to the determination of a certification decision.