OPTUM™

Outpatient Mental Health Request

Secure email to NYHARPAuthorizations@uhc.com or Fax: 877-339-8399

Provider Name:
Tax Identification Number:
Provider Contact Name:
Title:
Telephone Number:
Fax Number:
Member Name:
Medicaid ID:
Date of Birth:
Address:
Primary Diagnosis:
Secondary Diagnosis:
Tertiary Diagnosis:
Chronic Medical Conditions (include medical medications):
Date member admitted to this level of care:
Is this an initial service request? **(Circle One) Y / N**
Is this a concurrent service request? **(Circle One) Y / N**
Requested service start date:
Is the Member Prescribed Psychotropic Medication? **(Circle One) Y / N**
Name of the facility that the member is receiving psychiatric services from:
Psychiatrist/Psychiatric Nurse Practitioner Name:
Psychiatrist/Psychiatric Nurse Practitioner Phone Number:
Please List the Psychotropic Medications Below (include medication name, dosage, and frequency)
FOR PROS ONLY REQUESTS ONLY: Please do not request a clinic add-on if the member is receiving clinic services (e.g., medication management services, individual therapy services) at another agency as this is considered a duplication of services.

Member's Level of Functional Impairments (Circle One)			
Baseline	**Mild**	**Moderate**	**Severe**
Please describe the functional impairments the member is experiencing:			
Proposed treatment plan to target identified functional impairments noted above and to target the member's self-described person-centered goals:			
Person-Centered Goal #1:			
Intervention(s):			
Has the member made progress with this goal?			**(Circle One) Y / N**
If no, why?			
Person-Centered Goal #2:			
Intervention(s):			
Has the member made progress with this goal?			**(Circle One) Y / N**
If no, why?			
Person-Centered Goal #3:			
Intervention(s):			
Has the member made progress with this goal?			**(Circle One) Y / N**
If no, why?			
FOR PROS ONLY (please be advised all PROS notifications will have an authorization period of 6 months):			
Number of days per week the member will be attending PROS:			
Number of hours per day the member will be attending PROS:			

Requested Service Codes	**(circle the codes being requested for this member)**
Continuing Rehabilitation Services (CRS)	H2019
Clinical Treatment (CT)	T1015
Intensive Rehabilitation (IR)	H2018
Ongoing Rehabilitation and Support (ORS)	H2025

FOR ACT ONLY (please be advised all ACT notifications will have an authorization period of 6 months):
Number of visits per month:
Average length of visit:
FOR ALL OTHER SERVICES:
Requested Service Name (e.g., CDT, IPRT):
Requested Service Code:

_____ _____

Signature of Provider Completing the Request **Date**