UnitedHealthcare®
MILITARY & VETERANS

Outpatient Treatment Request

Please answer each question and fax to 1-877-581-1590.

Beneficiary Name: Last	First	M.I.	Beneficiary ID:
Beneficiary Address: Street	Apt. No.	City	State ZIP Code
Date of Birth: (mm/dd/yyyy) _____ / _____ / _____			Authorization Number:
Provider Name:			Today's Date: (mm/dd/yyyy) _____ / _____ / _____
Provider Address: Street		City	State ZIP Code
Provider Phone #:	Provider Tax ID:		Provider NPI:
Provider Fax #:			

Disorder(s) being treated (Axes I & II)	
Axis I:	
Axis II:	
Axis III:	☐ None ☐ Chronic pain ☐ Thyroid ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ TBI ☐ Asthma/pulmonary disease ☐ Kidney disease ☐ Other (specify):_____

1. How long ago did the patient first experience symptoms related to the primary diagnosis?
   ☐ <6 months ☐ 7-12 months ☐ 13-24 months
   ☐ >24 months

2. History of psychiatric hospitalization:

   How many times has the patient been hospitalized for a psychiatric condition?
   ☐ none ☐ 1 ☐ 2 ☐ 3+

   If the patient was hospitalized within the past 12 months, how long ago was the most recent hospitalization?
   ☐ 0-3 months ☐ 4-6 months ☐ 7-12 months ☐ n/a

   What was the duration of the most recent hospitalization?
   ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ >10 days ☐ n/a

3. Symptoms/functional impairment:

	None	Mild	Moderate	Severe
Depression	☐	☐	☐	☐
Mania	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐
Eating disorder	☐	☐	☐	☐
Substance use/abuse/dep	☐	☐	☐	☐
Cognitive impairment	☐	☐	☐	☐
Work/school	☐	☐	☐	☐
Family/relationships	☐	☐	☐	☐
Impulsivity	☐	☐	☐	☐
Aggressive behavior	☐	☐	☐	☐

4. Is adherence with medical treatment a problem?
   ☐ Yes ☐ No ☐ Do not know

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5. Is the patient currently receiving substance abuse treatment?
☐ Outpatient ☐ Inpatient ☐ None

6. Has the patient previously been treated for substance abuse?
☐ Yes ☐ No ☐ Do not know

Has the patient been in AA/NA?
☐ Yes* ☐ No
*If yes, when? ☐ In the past ☐ Now

7. Has the patient been referred for medication evaluation?
☐ Yes ☐ No ☐ Not indicated

8. Is the patient currently receiving prescriptions for psychotropic medication(s)?
☐ Yes ☐ No (If no, skip to question 13)

If yes, check:
☐ Antidepressant ☐ Anti-anxiety
☐ Antipsychotic ☐ Mood stabilizer
☐ Sedative/hypnotic ☐ Anticonvulsant
☐ Stimulant

9. Who is prescribing these medications?
☐ Myself ☐ Psychiatrist ☐ Other medical clinician

10. If you are not the prescribing clinician, have you initiated contact with the prescribing clinician?
☐ Yes ☐ No ☐ No, but contact planned

11. Is the patient adhering with the prescribed medications?
☐ Yes ☐ No ☐ Uncertain

12. Number of sessions to date in this episode of treatment:
☐ <10 ☐ 11-15 ☐ 16-20 ☐ >20

13. Expected outcome / prognosis
☐ Return to normal functioning
☐ Expect improvement, anticipate less than normal functioning
☐ Relieve acute symptoms, return to baseline functioning
☐ Maintain current status, prevent deterioration

14. Frequency of sessions:
☐ Less than once a week
☐ Weekly
☐ Greater than once a week

15. Progress update
☐ Adhering, progressing and improving – needs more treatment
☐ Adhering, progressing and improving – plan for discharge
When is anticipated discharge? _____ / _____ / _____
☐ Adhering, not progressing, not improving
☐ Not adhering, not progressing, not improving

16. Planned treatment request/number of sessions:

90832 _____	90785 _____	99211 _____
90833 _____	90853 _____	99212 _____
90834 _____	99201 _____	99213 _____
90836 _____	99202 _____	99214 _____
90837 _____	99203 _____	99215 _____
90838 _____	99204 _____	Other _____
90846-90847 _____	99205 _____	Other _____

Additional Comments

Provider Signature: _____ Credentials: _____

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