Lake County Physicians' Association

Outpatient Behavioral Health Treatment Request Form

Fax To: 815-962- 5090

IS THIS AN URGENT REQUEST? **If yes, please call 847-360-2616 prior to submitting this form.**

Patient Name | DOB | Patient ID/Plan | Primary Care Physician

Behavioral Health Provider (BHP) | BHP Phone | BHP Fax

Diagnosis: **Serious Mental Illness (SMI) _____** **Non Serious Mental Illness (Non-SMI) _____**

Primary Diagnosis(s) / ICD-9/10 (required) **Axis I** _____ _____ _____
Secondary Diagnosis (If Applicable) **Axis II** _____
Medical Conditions **Axis III** _____
Current Stressors **Axis IV** _____
Current Functioning (GAF) (required) **Axis V** _____

How many prior providers has patient had? **0 1 2 3 4 5 >5**

How long has patient been in treatment (circle)? **<1 year 1-2 years 3-4 years >5 years** **# of IP treatments: _____**

Risk Level (circle): None Ideation/passive Ideation/active Ideation/impulse Plan Gesture Attempt self/other

Impairment:	**0/none**	**1/mild**	**2/moderate**	**3/severe**	
Mood Disturbance:	0	1	2	3	n/a
Anxiety:	0	1	2	3	n/a
Impulsive/Reckless/Aggressive:	0	1	2	3	n/a
Job/School Performance:	0	1	2	3	n/a
Social Relations/Marital/Family:	0	1	2	3	n/a
Medical/Physical (includes wt change):	0	1	2	3	n/a
Psychosis/Hallucinations/Delusions:	0	1	2	3	n/a
Substance Use/Abuse/Dependence:	0	1	2	3	n/a

Type: Depression Mania Mixed

Type & Frequency: _____

Current Medications:

_____

Treatment Progress (circle): No Improvement Some Improvement Moderate Improvement Marked Improvement

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Please submit TREATMENT PLAN and/or OFFICE NOTES with this form

Type of Service Requested: 90862 90805 90806 90847 Other: _____ **# of Sessions Requested:** _____

Current Frequency of Sessions: _____ **week / month / year** (circle)

Date of 1st visit with patient: _____ Date of last visit with patient: _____

Total visits this year: _____ Total visits to date (from start of care): _____

Provider Signature: _____ **Date:** _____

Referral is not a guarantee of payment and does not authorize benefits for non-covered services * Eligibility and benefits will be determined at the time the claim is submitted * Members are responsible for knowing their benefits* * Any services not indicated on this form will need additional authorization. *****