



Submit to:
 Aetna Better Health of Illinois UM
 Phone 1-866-329-4701/Fax 1-844-528-3453

Aetna Better Health[®] of Illinois

Outpatient Treatment Request Form

Please print clearly – incomplete or illegible forms will delay processing.
ALL SECTIONS MUST BE COMPLETED.

Date _____

Member Information

Name _____
 DOB _____
 Member ID # _____

Provider Information

Provider Name (Print) _____
 Provider / Agency Tax ID # _____
 Provider / Agency NPI Sub Provider # _____
 Phone # _____ Fax # _____

Current ICD Diagnosis

Primary _____
 Secondary _____
 Tertiary _____
 Additional _____
 Additional _____

Has contact occurred with PCP? Yes No

 First date seen by Provider / Agency _____
 Last seen by Provider / Agency _____
 SPMI / SED Yes No

THERAPEUTIC APPROACH / EVIDENCE BASED TREATMENT USED

LEVEL OF IMPROVEMENT TO DATE

Minor Moderate Major No progress to date Maintenance treatment of chronic condition

Barriers to Discharge

RISK ASSESSMENT

Suicidal: None Ideation Date of last episode _____ Planned Imminent Intent History of self-harming behavior
 Homicidal: None Ideation Date of last episode _____ Planned Imminent Intent History of harm to others
 Safety Plan in place? (If plan or intent indicated): Yes No
 If prescribed medication, is member compliant? Yes No

CURRENT MEASURABLE TREATMENT GOALS

Member Name _____

REQUESTED AUTHORIZATION (PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

BH OP SERVICES (BILLED WITH CPT CODES)	FREQUENCY: HOW OFTEN SEEN	INTENSITY: # UNITS PER VISIT	REQUESTED START DATE FOR THIS AUTH	REQUESTED END DATE FOR THIS AUTH (NOT TO EXCEED 6 MONTHS)
<input type="checkbox"/> Individual Therapy (90832, 90834, 90837)				
<input type="checkbox"/> Group Therapy (90853)				
<input type="checkbox"/> Family Therapy (90847, 90849)				

CMHC ONLY

<input type="checkbox"/> Case Management T1016 (15 min units) HFS benefit limit of 240 hours per state fiscal year, per member. Non-participating providers must request authorization prior to service.				
<input type="checkbox"/> Assertive Community Treatment H0039 (15 min units)				
<input type="checkbox"/> Crisis Intervention H2011 (15 min units)				
<input type="checkbox"/> Community Support H2015 (15 min units) <input type="checkbox"/> Check here if member has exhausted the allowed 360 lifetime units since 12/1/2018				
<input type="checkbox"/> Community Support Team H2016 (15 min units) <input type="checkbox"/> Check here if member has exhausted the allowed 360 lifetime units since 12/1/2018				
<input type="checkbox"/> Psychosocial Rehabilitation H2017 (15 min units) <input type="checkbox"/> Check here if member has exhausted the allowed 800 lifetime units				

IF YOU ARE A NONPARTICIPATING PROVIDER ONLY, PLEASE INDICATE HERE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR. OTHER CODES (REQUESTED):

Have traditional behavioral health services been attempted (e.g. individual / family / group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Confirm by checking here that the following are included with this OTR request:

- IMCANS or MH or SUPR /Treatment plan LOCUS, if applicable 30 days of progress notes when requesting additional services

Clinician Signature

Date

Clinician Signature

Date

PLEASE ATTACH IM – CAT