

# HEALTHCHOICE

3545 NW 58<sup>th</sup>, Suite 500, Oklahoma City, OK 73112

Phone: 1-800-543-6044 or 1-405-717-8879

FAX: 1-405-717-8947 or 1-405-717-8935

## OUTPATIENT CHEMICAL DEPENDENCY REQUEST

**This information is private and confidential.**

(◆) Billing Provider: \_\_\_\_\_ (◆) Date: \_\_\_\_\_

(◆) Billing Address: \_\_\_\_\_

(◆) TIN: \_\_\_\_\_ Contact Person : \_\_\_\_\_

Phone: \_\_\_\_\_ (◆) Fax # : \_\_\_\_\_

(◆) Patient: \_\_\_\_\_ (◆) DOB: \_\_\_\_\_

(◆) Member: \_\_\_\_\_ (◆) Member ID #: \_\_\_\_\_

**(◆) DSM IV Diagnosis:**

Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Axis IV (List Stressors) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Axis V \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Brief History of Substance Abuse: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

History of Previous Chemical Dependency/Psychiatric Treatment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment Goals: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Progress in Treatment/Current Status: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe the proposed treatment and why you consider it to be medically necessary at this time: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of Sessions Requested: \_\_\_\_\_ Beginning Date of Additional Sessions: \_\_\_\_\_

Please indicate type(s) of service provided BY YOU, and the frequency:

- |  |                                 |                                  |                                |                                      |
|--|---------------------------------|----------------------------------|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Medication Management 90862             | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy (20-30 min.) 90804 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy (45-50 min.) 90806 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Indiv. Psychotherapy w/Med. Mgmt. 90807 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Family Psychotherapy (60-90 min.) 90847 | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Group Therapy (60-90 min.)              | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Intensive Outpatient                    | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____                             | <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Qtrly | <input type="checkbox"/> Other _____ |

**NOTE: Please FAX Initial Evaluation, An extension of services requires telephone update.**

\*\*\*\*\*FOR HCMD USE ONLY (Do Not Write Below This Line)\*\*\*\*\*

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** These benefits are applicable only if the patient is eligible for HealthChoice, and are subject to ALL POLICY PROVISIONS. Please remember to verify benefits and eligibility by calling 1 (800) 782-5218.

**MEDICARE PATIENTS:** If HealthChoice is supplement, all services requested must initially be approved by Medicare.

**(◆) DENOTES INFORMATION REQUIRED TO COMPLETE REVIEW FOR CERTIFICATION**