AmeriHealth Caritas™
New Hampshire

Behavioral Health Outpatient Treatment Request Form (OTR)

Submit to Utilization Management
Fax: 1-833-469-2264
For assistance, please call 1-833-472-2264

Please note: Out-of-network providers require prior authorization for all services. If you have questions about services that require a prior authorization, please contact AmeriHealth Caritas New Hampshire at 1-833-472-2264.
Incomplete or illegible forms will delay processing.

Please note: Electroconvulsive therapy (ECT), transcranial magnetic stimulation (TMS), and vagus nerve stimulation (VNS) are to be requested using the forms specific to those services.

Member information	
Patient name:	Date of birth:
Medicaid or member ID number:	Last authorization number (if applicable):

Provider information	
Provider name:	
☐ In network ☐ Out of network ☐ In credentialing process	
Group/agency name:	
Provider credential: ☐ M.D. ☐ Ph.D. ☐ LMHP ☐ LAC ☐ Nurse practitioner ☐ Other, please specify:	
Physical address:	
Telephone number:	Fax number:
Medicaid, provider, or NPI number:	**Contact name:**
If out of network, please complete the fields below (Utilization Management will contact provider directly before giving an authorization)**:** 1. Specialty of provider to meet the needs of the member: 2. Continuity of care concerns: 3. Accessibility/availability of provider: 4. Clinical rationale:	

Previous or current mental health (MH) and/or substance use disorder (SUD) treatment	
☐ None **or** ☐ MH/SUD outpatient ☐ MH/SUD intensive outpatient ☐ MH/SUD partial hospitalization program ☐ MH inpatient ☐ SUD residential ☐ Other (provide specifics):	
Substance use: ☐ None ☐ By history **or** ☐ Current/active Substances used, amount, frequency, and last used:	**Tobacco use:** ☐ None ☐ By history **or** ☐ Current/active
Previous or current waiver services: ☐ Yes ☐ No If yes, give specifics:	
DSM diagnosis: Primary Dx: Secondary Dx: Medical Dx:	
Primary care provider (PCP) and other communication: Has information been shared with the PCP and other providers regarding: 1. The initial evaluation and treatment plan? ☐ Yes ☐ No	2. The updated evaluation and treatment plan? ☐ Yes ☐ No
Other behavioral health provider names and last notified:	
PCP name and date last notified:	
If no, please explain:	
Is the member's family and support system involved in treatment planning and execution? ☐ Yes ☐ No If no, explain:	
Was the member given a choice in their behavioral health/substance use provider? ☐ Yes ☐ No If no, explain:	

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Current risk/lethality						
	1 — None	**2 — Low**	**3 — Moderate**	**4 — High**	**5 — Extreme**	**Is member prescribed medications?**
Suicidal	☐	☐	☐	☐	☐	☐ Yes ☐ No Prescribing physician(s) name(s):
Homicidal	☐	☐	☐	☐	☐	☐ Yes ☐ No Prescribing physician(s) name(s):
Assault/violent	☐	☐	☐	☐	☐	Is the member compliant with medications? ☐ Yes ☐ No Please list medications and dosages:

Treatment request
☐ **Individual** ☐ **Group** ☐ **Family** ☐ **Medical management**
☐ **Other, please specify:**
Presenting problem (list primary complaint or problem to be addressed)**:**
Treatment plan and goals (ist measureable treatment goals)**:**
Overall progress toward goals: ☐ 1 None/minimal ☐ 2 Moderate ☐ 3 Met
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Number of sessions requested:	**Frequency of visits:**	**CPT/HCPCS codes:**
Start date:	**Estimated end date:**	
Provider signature:		**Date:**