

Behavioral Health Outpatient Treatment Request Form

VIP Care

When complete, please fax to **1-855-396-5750**.

Please type or print clearly. Incomplete and illegible forms will delay processing.

Prior authorization is required for outpatient services. For psychological and neurological testing, please submit the Testing Outpatient Request Form.

Electroconvulsive therapy (ECT) services must have prior authorization by telephonic review. Please call 1-866-688-1137.

Out-of-network providers: Prior authorization and a non-contracted provider form are required for all services.

Member name: Member ID number: Social Security number: Date of birth: Member address: City, state, ZIP code: Phone: Who referred member for treatment? Self \Box Primary care provider (PCP) \Box state agency \Box Other:	Member information				
Member address: City, state, ZIP code: Phone: Who referred member for treatment? Self Primary care provider (PCP) State agency Other:	Member name:		Member ID number:		
Who referred member for treatment? Self Primary care provider (PCP) State agency Other: Name of referring agency: Phone: Treating provider information Name (with credentials): In network Out of network Phone: Address: Group name/number: Contact name: Treating provider signature: Reason for services Primary reason or complaint: Service codes requested: Frequency: DSM diagnosis List all Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses (behavioral health and medical). Supports and care coordination 1. Is the member currently participating in any vocational services? Yes Name there coordination with other substance use providers? Yes No State member been evaluated by a psychiatrist? Yes No State coordination of care with other behavioral health providers? Yes No State coordination of care with medical providers? Yes No	Social Security number:		Date of birth:		
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Treating provider information Name (with credentials): NPI:	Who referred member for treatment? \Box Self \Box Pr	rimary care p	rovider (PCP) 🗆 State agency 🗆 Other:_		
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	Medications				
Prescribing providers: Medications and dosages:	Is member on prescribed medication? \Box Yes \Box N	No Is mei	mber compliant with medication? \square Yes	□ No	
	Prescribing providers:	Medio	ations and dosages:		
Place attach the current treatment plan include documentation related to progress on goals and any changes made as a re-					
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