



® Certification Request/Follow-Up Outpatient Behavioral Health Treatment Plan– Confidential

Identifying Data	DSM-IV Diagnosis
Patient's Name _____	Axis I: / / / ./ / / / / / / / / / / / / / /
Sex: { } Female { } Male	Axis II: / / / ./ / / / / / / / / / / / / / /
Subscriber #: _____ Date of Birth: _____	Axis III: _____
Provider's Name/Credentials: _____	Axis IV: _____
Clinic Name: _____	Axis V: Current: _____ Highest in last year: _____
Address: _____	Expected GAF at Discharge: _____
City State/Zip: _____	
Fax #: _____ Phone #: _____	
Billing Tax ID #: _____	
Date of Intake: _____ Total Sessions to date: _____	
Date of last session: _____ Referral Source: _____	

Treatment Plan

<p>I. Discharge Criteria (What is your discharge criteria?) Please list date(s)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>IV. Treatment Modality & Frequency of Service</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Psychiatric Codes & Treatment Requested</th> <th style="text-align: left;">Frequency/Month</th> <th style="text-align: left;"># of sessions requested</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 908 _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> 908 _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Evaluation and Management Codes</p> <p><input type="checkbox"/> 99 _____</p> <p><input type="checkbox"/> Other _____</p> <p>Additional Clinical Information:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	Psychiatric Codes & Treatment Requested	Frequency/Month	# of sessions requested	<input type="checkbox"/> 908 _____	_____	_____	<input type="checkbox"/> 908 _____	_____	_____
Psychiatric Codes & Treatment Requested	Frequency/Month	# of sessions requested								
<input type="checkbox"/> 908 _____	_____	_____								
<input type="checkbox"/> 908 _____	_____	_____								
<p>II. Treatment Provided (check all that apply)</p> <p><input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> Family Therapy</p> <p><input type="checkbox"/> Medication Management <input type="checkbox"/> Group Therapy</p> <p><input type="checkbox"/> Individual Psychotherapy</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>									
<p>III. Expected Outcome & Prognosis</p> <p><input type="checkbox"/> Return to normal functioning</p> <p><input type="checkbox"/> Expect improvement, anticipate less than normal functioning</p> <p><input type="checkbox"/> Relieve acute symptoms, return to baseline functioning</p> <p><input type="checkbox"/> Maintain current status/prevent deterioration</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>									
	<p>Providers Signature Date Prepared</p>									

