Behavioral Health — Out-of-Network Outpatient Treatment Request

Facility/primary care providers should refer directly to ta contracted Anthem Blue Cross (Anthem) behavioral health (BH) provider for Medi-Cal Managed Care (Medi-Cal). If out-of-network, the outpatient BH servicing provider is to complete this request and submit for authorization. Please print clearly. Incomplete or illegible forms will delay processing.

Phone: **888-831-2246**
Fax: **855-473-7902**

Member information	
Patient name:	Date of birth:
Patient address:	
Patient phone number:	Medi-Cal ID #:
Last authorization #:	
Provider information	
Direct servicing provider name/credentials:	
Physical address:	
Provider email:	
Phone:	Facsimile #:
Provider NPI:	Tax ID #:
Specify reason requested (such as, in-network provider not in area, language, clinical specialty):	
Continuity of care: ☐ Yes:_____ ☐ No: _____	
Provider pending completion of contracting with Anthem for BH Medi-Cal: ☐ Yes ☐ No	
Previous BH/substance use treatment? ☐ None ☐ Outpatient ☐ Medical history ☐ Substance use ☐ Inpatient ☐ Medical history ☐ Substance use ☐ Other:	

https://providers.anthem.com/ca

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List names/data including hospitalizations, if applicable:
Substance use: ☐ None ☐ By history ☐ Current/active
Tobacco use: ☐ None ☐ By history ☐ Current/active
Substance(s) used, amount, frequency, and last used:
DSM-5, DSM-5-TR, and/or ICD-10 diagnoses:
If the member has a substance use and/or HIV diagnosis, has a consent to release information for these related conditions been obtained? ☐ Yes ☐ No ☐ N/A

Primary care physician (PCP) communication

Has information been shared with the PCP regarding:

- The individual evaluation and treatment plan? ☐ Yes ☐ No
- This updated evaluation and treatment plan? ☐ Yes ☐ No
- Per Medi-Cal requirements, have you sent notification to the PCP of behavioralhealth services? ☐ Yes ☐ No

PCP name:	
PCP phone:	Date last notified:
If no, explain:	

Treatment goals

List primary complaint/problem to be addressed:

List measurable treatment goals, standardized assessments used, and scores:

Discharge goals

Describe how you will know the patient is ready to terminate treatment:

Current risk/lethality					
Suicidal	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme
Homicidal	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme
Assault/violent behavior	☐ 1 None	☐ 2 Low	☐ 3 Moderate	☐ 4 High	☐ 5 Extreme

Interventions for current risk/lethality (2 to 5):

Is member currently participating in any community-based support groups/interventions? Please list:

Please answer *yes* or *no* to the following questions:

- Are the member's family/supports involved in treatment? ☐ Yes ☐ No
- Coordination of care with other BH providers? ☐ Yes ☐ No
- Coordination of care with medical providers? ☐ Yes ☐ No
- Has member received services at the county? ☐ Yes ☐ No
- Has member been evaluated by a psychiatrist? ☐ Yes ☐ No
- Medical psychiatric evaluation done (even if PCP providing meds)? ☐ Yes ☐ No

Medication given by: ☐ Psychiatrist ☐ PCP ☐ Nurse practitioner/physician's assistant

List medications/dosages:

Overall progress toward goal:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
None	Minimum	Moderate	Maximum	Met

Compliance with treatment:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
None	Minimum	Moderate	Maximum	Met

If 1 or 2, please explain:

Requested authorization	
Services requested: ☐ Individual therapy ☐ Group therapy	
Total sessions requested:	Frequency of visits:
CPT® codes:	Number of visits per code:
Estimated number of sessions to complete treatment episode:	Requested start date:
Provider signature:	
Date:	