Behavioral Health — Out of Network Outpatient Treatment Request

Please print clearly — incomplete or illegible forms will delay processing.

Facility/primary care providers should refer directly to a 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.

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 with Medi-Cal: ☐ Yes ☐ No	

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Previous BH/substance use treatment? ☐ None ☐ Outpatient ☐ Medical history ☐ Substance use ☐ Inpatient ☐ Medical history ☐ Substance use ☐ Other: _____
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 behavioral health 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 None	☐ 2 Minimum	☐ 3 Moderate	☐ 4 Maximum	☐ 5 Met
Compliance with treatment:				
☐ 1 None	☐ 2 Minimum	☐ 3 Moderate	☐ 4 Maximum	☐ 5 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:	