OUTPATIENT TREATMENT REQUEST

(OTR) Effective 01/01/2011

BlueCross BlueShield of Texas

Instructions: Please fill out and print, or print form and fill out legibly in black ink. Fax to BCBSTX at 877-361-7646. All fields in shaded areas are mandatory.

Patient/Member Information

Patient Name____________________

Patient DOB____________________

Member Name____________________

Group #____________________

Subscriber # ____________________

Provider Information (Individual and/or Group)

Provider Name____________________

City____________________

NPI # ____________________

Address ____________________

State____________________ Zip__________

Fax #__________ Phone #__________

Has the member been screened for possible substance use disorder? ☐ Yes ☐ No

DSM-IV or ICD-9 Diagnosis *numeric and description*

Axis I____________________

Axis II ____________________

Axis III ____________________

Axis IV ____________________

Axis V Current ____________________ Highest Past Year __________

Primary Diagnosis

Targeted Symptoms of Treatment:

____

____

____

____

Current Treatment

Stage of Therapy: (Check one) Initiation ☐ Continuation ☐ Maintenance ☐

Type of Psychotherapy

- ☐ Cognitive Behavioral
- ☐ Dialectical Behavioral
- ☐ EMDR
- ☐ Interpersonal
- ☐ Psychoanalytic
- ☐ Psychodynamic
- ☐ Psycho-educational
- ☐ Supportive
- ☐ Other (Specify):

____

Goals for Treatment

Goal #1: ____________________

Intervention for Goal #1 ____________________

Goal #2: ____________________

Intervention for Goal #2 ____________________

Authorization should start on: ____________________(date)

Anticipated Treatment Outcome:

- ☐ Discharge from Care Date:__________
- ☐ Transition to Maintenance Care Date:__________
- ☐ Other ____________________

The patient's care is being coordinated with the following individuals: (Check all that apply)

PCP__________ Psychiatrist __________ Other Therapist __________ Other __________

If no coordination with others, why?____________________

Requested Treatment (Number and Frequency)			Current Medications	
Modality and CPT Code	**Req**	**Freq**	**Psychiatric Meds (Name/Dose)** Is this Patient on psychotropic meds for condition being treated? ☐ Yes ☐ No	**Other Meds**
☐ 90804 Individual	____	____	____	____
☐ 90805 Ind. w/Meds	____	____	____	____
☐ 90806 Individual	____	____	____	____
☐ 90807 Ind. w/Meds	____	____	____	____
☐ 90847 Couple/Family	____	____	____	____
☐ 90853 Group	____	____	____	____
☐ 90862 Med Mgmt	____	____		
☐ Other ______	____	____		

Additional Clinical Information:____________________

My signature confirms that I am providing the requested services:

Signature____________________ Date__________

OTR

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

55583.0312