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_____ Member Name_____

Patient DOB_____ Group #_____

Subscriber # _____

Provider Information (Individual and/or Group)

Provider Name_____ Address _____

City_____ State_____ Zip_____

NPI # _____ 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)

Modality and CPT Code	Req	Freq
☐ 90832 Individual, 30 min		
☐ 90833 Ind. with E/M, 30 min		
☐ 90834 Individual, 45 min		
☐ 90836 Ind. with E/M, 45 min		
☐ 90837 Individual, 60 min		
☐ 90847 Couple/Family		
☐ 90853 Group		
☐ Other _____		

Current Medications

Psychiatric Meds (Name/Dose)

Is this Patient on psychotropic meds for condition being treated? ☐ Yes ☐ No

_____

_____

_____

_____

_____

_____

Other Meds

_____

_____

_____

_____

_____

_____

Additional Clinical Information:_____

My signature confirms that I am providing the requested services:

Signature_____ Date_____

O T R