

PLEASE NOTE: All services requiring pre-certification (other than on an emergency basis) must be approved in advance by the HMO's Medical Director/designee. **ALL ADMISSION DOCUMENTATION MUST BE SUBMITTED ALONG WITH THIS FORM.** Pre-certification is subject to all terms and conditions of the Health Service Contract and is only valid for eligible health plan member at time of service.

Today's Date: _____ Office Contact Person: _____

Requesting Provider's Name: _____ Contact Phone: _____ Fax: _____

TPI No. _____ NPI No.: _____

Member Name: _____ Member I.D.: _____ D.O.B.: _____

Member Phone No. _____

Facility Name Performing the Service/Procedure: _____ Phone No.: _____

Expected Date of Admission/Procedure: _____

Procedure(s) Requested: _____

Type of Setting (circle one): **Inpatient** **Outpatient** **Observation** **Other** _____

Axis I _____ Axis II _____ Axis III _____
(ICD-9 Code)

Axis IV _____ Axis V _____

Evaluation of Initial Treatment: _____

For continuation of therapy requests, please include current symptoms, response to past treatment, specific therapeutic interventions to be used in therapy and frequency of contact.

Medications, Dose, Frequent Side Effects and Prescribing M.D. _____

New Treatment Goals and Target Dates: _____

<u>Mood</u>	<u>Cognition</u>	<u>Thought Content</u>	<u>Behavior</u>	<u>Activity</u>
<input type="checkbox"/> Anger	<input type="checkbox"/> Decrease Concentration	<input type="checkbox"/> Flight of Ideas	<input type="checkbox"/> Aggression	<input type="checkbox"/> Decrease in Energy
<input type="checkbox"/> Apathy	<input type="checkbox"/> Distractibility	<input type="checkbox"/> Loose Association	<input type="checkbox"/> Obsessions/Compulsions	<input type="checkbox"/> Psychomotor Retardation
<input type="checkbox"/> Blunted/Flat Affect	<input type="checkbox"/> Impaired Abstract Thinking	<input type="checkbox"/> Hypertalkative	<input type="checkbox"/> Oppositional/Defiant	<input type="checkbox"/> Restlessness
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Self-Injurious	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Elevated/Expansive	<input type="checkbox"/> Difficulty Making Decisions	<input type="checkbox"/> Racing Thoughts	<input type="checkbox"/> Social Withdrawals	<input type="checkbox"/> Impulsiveness
<input type="checkbox"/> Grandiosity	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Delusions	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hopelessness		<input type="checkbox"/> Grandiosity		
<input type="checkbox"/> Irritable		<input type="checkbox"/> Hallucinations		
<input type="checkbox"/> No Self Esteem		<input type="checkbox"/> Paranoid Ideation		
<input type="checkbox"/> Tearfulness		<input type="checkbox"/> Suicidal Ideation		
<input type="checkbox"/> Shift in Mood		<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Other: _____				

THIS PRECERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS. PAYMENT OF BENEFITS IS SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE MEMBER'S CONTRACT. REGARDLESS OF A DETERMINATION, MEDICAL DECISIONS REGARDING A COURSE OF TREATMENT ARE SOLELY BETWEEN THE PHYSICIAN AND THE PATIENT.

Member's Name: _____ Member I.D. _____

Anxiety/Phobia	Factors/Risks	Sleep Patterns	Eating Patterns	Substance Abuse
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Lack of Primary Support Group	<input type="checkbox"/> Hypersomnia	<input type="checkbox"/> Increase Appetite	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Panic Attack	<input type="checkbox"/> Work problems	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Decrease Appetite	<input type="checkbox"/> Drugs
<input type="checkbox"/> Phobic Responses	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Other _____	<input type="checkbox"/> Binge Eating	<input type="checkbox"/> Active
<input type="checkbox"/> Excessive Worry	<input type="checkbox"/> Financial Problems		<input type="checkbox"/> Self-Induced Vomiting	<input type="checkbox"/> Remission
<input type="checkbox"/> Other _____	<input type="checkbox"/> Previous MH/SA		<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Hospitalization			
	<input type="checkbox"/> Family HX of Suicide/Violence			
	<input type="checkbox"/> Recent Loss			
	<input type="checkbox"/> Impaired Judgment			
	<input type="checkbox"/> Other _____			

Suicidal: Yes No Explain: _____

Homicidal: Yes No Explain: _____

Emotional Trauma: Yes No Explain: _____

Sexual Trauma: Yes No Explain: _____

Physical Trauma: Yes No Explain: _____

Number of sessions being requested with this treatment plan to include CPT Code and frequency as well as Revenue Codes:

CPT Code	Units	Rev Code	Units	Rev Code	Units	Rev Code	Units	Rev Code	Units
<input type="checkbox"/> 90801 Initial Evaluation	_____	<input type="checkbox"/> 100	_____	<input type="checkbox"/> 124	_____	<input type="checkbox"/> 146	_____	<input type="checkbox"/> 912	_____
<input type="checkbox"/> 90806 Individual Therapy	_____	<input type="checkbox"/> 101	_____	<input type="checkbox"/> 126	_____	<input type="checkbox"/> 154	_____	<input type="checkbox"/> 913	_____
<input type="checkbox"/> 90847 Family Therapy with Member	_____	<input type="checkbox"/> 110	_____	<input type="checkbox"/> 134	_____	<input type="checkbox"/> 156	_____	<input type="checkbox"/> 1001	_____
<input type="checkbox"/> 90853 Group Therapy	_____	<input type="checkbox"/> 114	_____	<input type="checkbox"/> 136	_____	<input type="checkbox"/> 905	_____	<input type="checkbox"/> 1002	_____
<input type="checkbox"/> 90862 Medication Management (Psychiatrist Only)	_____	<input type="checkbox"/> 116	_____	<input type="checkbox"/> 144	_____	<input type="checkbox"/> 906	_____	<input type="checkbox"/>	(Other) _____

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Approved Denied Modified Comments: _____

MD Signature: _____

Nurse: _____

Authorization No. **00000**