BlueCross BlueShield of Montana

# FOCUSED OUTPATIENT MANAGEMENT PROGRAM

Instructions: Please print and fax completed forms to BCBSMT at **855-649-9681**. To speak to a Behavioral Health Outpatient Care Coordinator, call **855-313-8909.**

Date_____ ☐ Initial Clinical Submission ☐ Subsequent Clinical Submission

## Patient and Member Information

Patient Name_____ Subscriber Name_____

Patient Date of Birth_____ Subscriber ID_____

Group_____

## Provider Information (Individual and/or Group)

Provider Name_____ License_____ NPI _____

Address_____ City_____ State_____ Zip_____

Email Address_____ Phone_____ Fax_____

Current DX — Please include all ICD-10 codes and medical diagnoses that apply.

ICD-10 Code _____ DX Name _____ Specifier _____

ICD-10 Code _____ DX Name _____ Specifier _____

ICD-10 Code _____ DX Name _____ Specifier _____

ICD-10 Code _____ DX Name _____ Specifier _____

ICD-10 Code _____ DX Name _____ Specifier _____

Is the patient on medications? ☐ No ☐ Yes If yes, list the current medications and dosages.

Describe the patient's response to medications: ☐ Poor ☐ Moderate ☐ Excellent

Patient's history of services (recent hospitalizations, PHP, IOP, OP, etc.), including dates of service.

Date provider began treating patient _____

Describe the patient's response to therapy: ☐ Poor ☐ Moderate ☐ Excellent

What active symptoms are being treated?

Has the patient been screened for substance abuse issues? ☐ No ☐ Yes

If no, explain the reason the patient was not screened for substance abuse.

C U R

| Percentage of patient improvement since last review | | | | | |
|---|---|---|---|---|---|
| Please put an '✓' in one of the five spaces to the right of each area below. | 0-20% | 21-40% | 41-60% | 61-80% | 81-100% |
| Interpersonal skills, social relationships | | | | | |
| Coping with life stressors | | | | | |
| Functioning in occupational or school settings | | | | | |
| Strength of support system | | | | | |
| Resolution of problems/symptoms | | | | | |

Describe the patient's progress since the last review

Current Treatment Goal 1

Intervention for Goal 1

Current Treatment Goal 2

Intervention for Goal 2

What social supports and community resources (ex: support groups, church/synagogue/mosque, etc.) has the member accessed (currently or in the past)?

**Request for Service Coverage, this review**

Service Code Requests WITHOUT Add on Codes. (Examples: 90832, 90834, 90837, 90845, 90846, 90847, 90849, 90853, E & M codes)

CPT Code _____ Frequency _____ Start Date _____
CPT Code _____ Frequency _____ Start Date _____
CPT Code _____ Frequency _____ Start Date _____
E&M or other Code _____ Frequency _____ Start Date _____

**Service Code Requests WITH Add On Codes. (Indicate primary CPT code, and then add on code(s).**

Add on Code Examples: 90785, 90833, 90836, 90838,90840, 90863)

(1) CPT Code _____ Frequency_____Start Date _____
Add On Code _____ Frequency_____ Add On Code_____ Frequency _____
(2) CPT Code _____ Frequency_____Start Date _____
Add On Code _____ Frequency_____ Add On Code_____ Frequency _____
(3) CPT Code _____ Frequency_____Start Date _____
Add On Code _____ Frequency_____ Add On Code_____ Frequency _____

Anticipated treatment completion date _____

Additional comments

My signature confirms that I am providing the requested services

Signature _____ Date _____





C U R