ACR LME
Alamance-Caswell-Rockingham
319A N. Graham-Hopedale Rd.
Burlington, NC 27215

(336) 513-4200
1-888-543-1444
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www.acmhddsa.net

TREATMENT REQUEST FORM

Reminder: Substance Abuse requires a signed release.

CIRCLE ONE BELOW — CIRCLE ONE BELOW

P (pre-cert) or C (concurrent) and U (urgent w/justification) or R (routine) Request Date________

PATIENT INFORMATION

____
First, Middle Initial, Last Name Patient

____
Client D.O.B

Insurance (**circle one**): Medicare IPRS Medicaid ______________
Name other ins.

LME Client Record #_________ LME Authorization # ______________

First Date Seen for this Episode:______________________________
MM/DD/YY

PRACTITIONER INFORMATION

____
Practitioner Name / Credentials / ID#

Provider Agency__________________________________

Location Address _________________________________

____

____
Phone# &ext

DSM-IV DIAGNOSIS
(Please complete all five axis)

AXIS I:____________________________________ DD – NC-SNAP:__________ Date Scored:______________

AXIS II:____________________________________ **Target Population:**_________________________

AXIS III:____________________________________ Target Population Exp Date:____________________

AXIS IV:____________________________________

AXIS V: GAF Score **At First Session**_______________ **Highest In Past Year**____________ **Current**________________

CURRENT MEDICATIONS

Medication	Dosage	Frequency	Route (i.e. oral, topical, etc)

AUTHORIZATION REQUEST

How many times have you seen the client in current auth period? _________

Service Code: (ask by CPT, H-code, or State code)	**Dates requested**: mm/dd/yy – mm/dd/yy	**Quantity**	**Unit:** (per event, unit, day)	**Agency & Address/staff:** [actual staff providing service(s)]

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Client Name:______________________ LME Record#:______________ Date Requested:__________

If the patient's symptoms indicate they are in a crisis situation or in need of detox, please contact the LME for further treatment options.

CLINICAL APPROPRIATENESS

1. **Since last UR, changes in situation, environment, behaviors, symptoms, services, tx compliance:**

Behaviors: / **Interventions:**

**Severity is with 5 being most severe. ** Goal is with 10 being met.*

Behaviors	Interventions
a. ____________________	**a.** ____________________
1. Freq. ______________	**1. Freq.** ______________
2. Severity (1-5)*______________	**2. Duration** ______________
3. Other ______________	**3. By whom** ______________
Circle progress toward goal. 0 1 2 3 4 5 6 7 8 9 10**	
b. ____________________	**b.** ____________________
1. Freq. ______________	**1. Freq.** ______________
2. Severity (1-5)*______________	**2. Duration** ______________
3. Other ______________	**3. By whom** ______________
Circle progress toward goal. 0 1 2 3 4 5 6 7 8 9 10**	
c. ____________________	**c.** ____________________
1. Freq. ______________	**1. Freq.** ______________
2. Severity (1-5)*______________	**2. Duration** ______________
3. Other ______________	**3. By whom** ______________
Circle progress toward goal. 0 1 2 3 4 5 6 7 8 9 10**	

2. **Client hospitalized within past year? Y N Where? Adm/Discharge Date? Why?** ______________
____

3. **Emergency intervention types/dates since last review:** ______________________

4. **Was arrested/charged? Y N Reason?**______________________________

5. **Med changes? Y N Client Med compliant? Y N** ______________________

6. **Report current involvement of natural supports (family, school, church, DSS, DJJ, etc.):**
____
____

7. **How and under what circumstances are services being stepped down during this UR period? Explain step-down and/or discharge criteria/plans:** ______________________
____
____

______________________________ ______________________
Signature (Provider of Services) **Date**

Please use additional page for explanations if needed. *Revised 10/26/06*

Please Mail or Fax this completed document to the above-mentioned address or fax number.

INSTRUCTION SHEET TREATMENT REQUEST FORM

Reminder: Substance abuse requires a release.

Pre-Certification: New client or new service.

Concurrent: Client currently receiving the service requested.

Urgent: Based on medical necessity, the service requested needs to be processed within 48 hours.

Routine: Non urgent request processed within state standards.

Request Date: The date that the practitioner fills out the form.

Patient Information

- **Patient Name:** Client's legal first, last name, and middle initial if known. Please do not use nicknames.
- **Client's date of Birth:** Client's month, day, and year of birth.
- **Insurance (circle one):** Client's insurance information
- **LME Client Record #:** Client's LME medical record number.
- **LME Authorization number:** Authorization number from the current authorization. (This will be on your prior authorization.)

Practitioner Information

- **Practitioner Name/Credentials/ID#:** The name, credentials and therapist number of practitioner
- **Provider Agency:** Name of group/agency providing service(s).
- **Location Address:** Practitioner mailing address.
- **Phone number:** Practitioner phone number - please include area code and extension.
- **First Date seen for this episode:** A new episode starts with the initiation of treatment when a client hasn't been seen for six months or more.

DSM-IV Diagnosis:

- **Axis I:** DSM diagnosis code and name - Clinical Disorders, other conditions that may be a focus of clinical attention.
- **Axis II:** DSM diagnosis code and name - Personality disorder, Mental Retardation.
- **Axis III:** General Medical Conditions.

- **Axis IV:** Psychosocial and environmental problems.
- **Axis V:** Global Assessment of Functioning (GAF) score
  - **AT First Session:** Score when client was first seen
  - **Highest in Past Year:** Highest GAF score in the past year
  - **Current:** Clients current score at the time of the assessment

- **DD-NC-SNAP:** SNAP Score for Developmental Disability clients.
- **Date Scored:** Month/day/year SNAP scored.
- **Target Population:** State identified target population
- **Target Population Exp. Date:** Date the target population expires.

Current Medication

- **Medication:** Name of medication. If no medication, please put "none"
- **Dosage:** How much is client to take
- **Frequency:** How often is client to take the medicine
- **Route:** How is client to take medication (oral injections, topical, etc…)

Authorization Request

- **How many times have you seen the patient in the current authorization period?** Number of times you have seen the client for this episode of care.

- **Service Code:** Ask by CPT, HCPCS (H-code), or State Code.

- **Dates requested:** Span of time you are requesting – please use start and end date. e.g.: 3/20/06 – 6/20/06.

- **Quantity:** How much of what you are requesting. e.g.: 30 -The units, etc. will go in the next slot labeled units. The two together will look like "30" units.

- **Units:** How the visits are quantified. e.g.: events, units, days, hours.

- **Agency, Address, & Staff Name:** Agency, address, and staff providing service(s). Address is needed if provider has multiple locations.

Page 2 of form

Client Name: Client name

Record #: Client record number

Date Requested: The date that the practitioner fills out the form

If the patient's symptoms indicate they are in a crisis situation or in need of detox, please contact the LME for further treatment options.

Client appropriateness: (Please be as detailed as possible)

1. **Since last UR, changes in situation, environment, behaviors, symptoms, services, tx. compliance**: Make sure that the identified behaviors and interventions correspond with the Treatment Plan.
   - **Behaviors:** Behaviors should be specific and to the point. See last page of instructions for examples.
     - **Frequency**: List how often the behavior is happening. e.g.: once a day, once a month, and twice a week.
     - **Severity (1-5):** Circle the appropriate number with 5 being most severe.
     - **Other:** Is there anything else we may need to know about the behavior? e.g.: Where is it happening?
   - **Interventions:** List interventions used to address the behaviors.
     - **Frequency:** State how often the intervention is being used.
     - **Duration:** State how long the intervention is being used.
     - **By Whom:** List who did the intervention. e.g.: Community Support worker, Therapist, etc.
     - **Circle progress toward Treatment goal:** Circle the appropriate number - 10 being goal met.

2. **Client hospitalized within the past year?** Circle “Y” for Yes or “N” for no.
   - **Where:** State in which hospital the client was treated.
   - **Admission and Discharge Date:** List dates of hospitalization. e.g.: 2/2/06 – 2/10/06.
   - **Why:** State why the client was hospitalized. e.g.: suicidal, homicidal, etc.

3. **Emergency intervention types/dates since last review:** List types of emergency intervention such as Mobile Crisis, walk into Crisis Services, or went to the Emergency room. List the dates of Interventions.

4. **Was arrested/charged?** Circle “Y” for yes and “N” for no.
   Reason: State why the client was arrested or charged.

5. **Med changes?** Circle “Y” for yes and “N” for no.
   Client Med. Compliant? Circle “Y” for yes and “N” for no.

6. **Report current involvement of natural supports (family, school, church, DSS, DJJ, etc.)** List any natural supports and what their involvement is in the treatment of the client.

7. **How and under what circumstances are services being stepped down during this UR period? Explain step-down and/or discharge criteria/plans:** State the step-down and/or discharge plan.

Signature (Provider of Services): Sign the Treatment Request form.

Date: Date you are preparing form. Please note that all requests are date-stamped when received and that is the date that will be used when determining authorization timelines.

EXAMPLES OF BEHAVIORS AND INTERVENTIONS:

*Severity is with 5 being most severe. ** Goal is with 10 being met.*

Behaviors:	Interventions:
a. Isolation	a. Individual therapy once a week
1. Freq. Daily for 2 weeks	1. Freq. once a week
2. Severity (1-5)* 3	2. Duration 50 minutes once a week
3. Other Stays in bed most of day	3. By whom Jane Doe, LPC
Circle progress toward goal.** 0 1 (2) 3 4 5 6 7 8 9 10	
b. Crying	b. Group Therapy
1. Freq. Multiple times daily	1. Freq. Two weeks
2. Severity (1-5)* 5	2. Duration Weekly , 1:15 min.
3. Other Grief response	3. By whom Jane Dope, LPC
Circle progress toward goal.** 0 1 (2) 3 4 5 6 7 8 9 10	
c. Feelings of hopelessness	c. Group therapy
1. Freq. Average 2 times daily	1. Freq. Once every week
2. Severity (1-5)* 4	2. Duration weekly
3. Other Relationship problems	3. By whom Jane Doe, LPC
Circle progress toward goal.** 0 1 2 (3) 4 5 6 7 8 9 10	
d. Suicidal Ideation	d. 24 hr access, meds increase, supportive counseling
1. Freq. 1 time per week	1. Freq. As needed
2. Severity (1-5)* 5	2. Duration As long as needed
3. Other JUH discharge last week	3. By whom ACTT provider
Circle progress toward goal.** 0 (1) 2 3 4 5 6 7 8 9 10	
e. Verbal threats	e. Family counseling
1. Freq. Average 2 times daily	1. Freq. Once every week
2. Severity (1-5)* 4	2. Duration 1:15 minutes
3. Other toward brother/family	3. By whom John and Jane Doe
Circle progress toward goal.** 0 1 2 (3) 4 5 6 7 8 9 10	

You may always use additional pages for explanations if needed.