

OUTPATIENT TREATMENT REQUEST

(OTR) Effective 01/01/2011



BlueCross BlueShield
of Oklahoma

Instructions: Please fill out and print, or print form and fill out legibly in black ink. Fax to BCBSOK at 877-361-7660. 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)			Current Medications	
Modality and CPT Code	Req	Freq	Psychiatric Meds (Name/Dose) Is this Patient on psychotropic meds for condition being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Meds
<input type="checkbox"/> 90804 Individual	_____	_____	_____	_____
<input type="checkbox"/> 90805 Ind. w/Meds	_____	_____	_____	_____
<input type="checkbox"/> 90806 Individual	_____	_____	_____	_____
<input type="checkbox"/> 90807 Ind. w/Meds	_____	_____	_____	_____
<input type="checkbox"/> 90847 Couple/Family	_____	_____	_____	_____
<input type="checkbox"/> 90853 Group	_____	_____	_____	_____
<input type="checkbox"/> 90862 Med Mgmt	_____	_____	_____	_____
<input type="checkbox"/> Other _____	_____	_____	_____	_____

Additional Clinical Information: _____

My signature confirms that I am providing the requested services:

Signature _____ Date _____

OTR