WPS HEALTH INSURANCE

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway | P.O. Box 8190 | Madison, WI 53708-8190
608-977-5000

Outpatient Behavioral Health Treatment Request Form

CONFIDENTIAL

Please note: If all or parts of this form are not complete, we will be unable to process your request.

Member Information

Subscriber ID:	Group ID:
Member First Name:	Member Last Name:
Member DOB:	Gender: ◯ Male ◯ Female

Provider Information

Provider First Name:	Provider Last Name:	
Provider NPI:	Tax ID:	
Clinic Name:	Clinic Address:	
City:	State:	ZIP:
Clinic Phone:	Clinic Fax:	

Medical Information

Number of sessions to date: ◯ 1-10 ◯ 11-20 ◯ 21-50 ◯ 51-100 ◯ 100+

Date of intake:	Requested start date for authorization:
Number of visits requested:	CPT/HCPCS code:

1.		
2.		
3.		
4.		
5.		

DSM–V diagnosis codes/ICD-10 codes (Enter in format XXX.XX Example: ADHD combined type F90.2.)

Psychiatric diagnosis	1.	2.	3.
	4.	5.	6.
Substance use disorders	1.	2.	3.
	4.	5.	6.
Medical conditions	1.	2.	3.
	4.	5.	6.

Outpatient Behavioral Health Treatment Request Form

Assessment

Complete the following assessment of the member in detail. Please submit any additional relevant information on a separate sheet of paper with this request.

Risk of harm:
Please describe level of self/other harm risks and the distress associated with it. Include whether there is intention, means, and plan as well as the chronicity. Include behaviors associated with substance use that also increases risk (loss of control as it relates to harmful behavior).

Functional status:
Please specify the level of impairments noted, including interpersonal, vocational, sleep disturbance, problems in school, social activities, legal consequences, impairing dietary habits, and medical impairments (i.e. low potassium, liver disease, and BMI below 17.5).

Co-morbidity:
Please describe how the assessed conditions interact and exist concurrently. Are the member's present conditions adversely affecting each other (and if so, how much)?

Recovery environment:
What stressful life circumstances currently exist and how do they impact the member's ability to function? Please include life phases, family issues, current substance use in the home, problems with shelter, limited resources, etc.

Outpatient Behavioral Health Treatment Request Form

Assessment

Treatment history/response and history of recovery:
Please summarize the member's treatment history, response to treatment, periods of stability/recovery, and details of ability to control symptoms. Include medications prescribed and response.

Willingness to engage in treatment and level of recovery:
Does the member show motivation for change or acceptance of their illness? Does member show recognition or responsibility in his/her personal role for recovery? How engaged is the member in the treatment process?

Treatment planning:
What is the current treatment plan? Please include goals, interventions, time frames, anticipated outcomes, and discharge plan. Support your request with clinical rationale that supports the level of care/intensity of services you are requesting and include the member's response to your interventions.

Additional comments:
Please document any additional relevant clinical information that supports your request for care.

When complete, please return this form to:

WPS Employee Group Members:
WPS Health Plan
Attn: Integrated Care Management
P.O. Box 1229, Madison, WI 53701-1229
Phone: 800-977-7178 | Fax: 608-226-8016

All other Members:
WPS Health Insurance
Attn: Integrated Care Management
P.O. Box 8190, Madison, WI 53708-8190
Phone: 800-333-5003 | Fax: 608-226-4777