KAISER PERMANENTE®

Mental Health Service
Psychiatric Medication Management (with Therapy)
Reauthorization Request

>> Incomplete forms may delay reauthorization << **>> One form per patient <<**

Please fax completed form to the Mental Health Access Center(MHAC) fax number listed below.
MHAC Fax: 206-630-1683 / Phone: 206-630-1680 or toll-free 1-888-287-2680
Mailed forms are accepted as well: Kaiser Permanente, MHAC, P.O. Box 34799, Seattle WA 98124-1799

Provider Name: _____ **Today's Date:** _____

Agency: _____ **Consumer Name:** _____

Phone Number: _____ **Consumer Number:** _____

Fax Number: _____ **Date of Birth:** _____

TIN: _____

*** **If you need additional space please attach separate notes to this form. Thank you.** ***

Date Current Episode of Care Began: _____

1. **Suicidal/ Homicidal Ideation/ Thoughts of Serious Self Harm**: Current: ☐ Yes ☐ No Past: ☐ Yes ☐ No
   Current Suicide Plan: ☐ Yes ☐ No Current Suicide Intent: ☐ Yes ☐ No Past Attempts: ☐ Yes ☐ No
   Current Homicide Plan: ☐ Yes ☐ No Current Homicide Intent: ☐ Yes ☐ No Past Attempts: ☐ Yes ☐ No

   If "yes" to any Suicidal/Homicidal symptoms, please address in Treatment Plan, below.

2. **Does the patient have an alcohol/substance use problem**? ☐ Yes ☐ No
   Has the patient been referred for treatment? ☐ Yes ☐ Yes, but patient declined ☐ No

3. **Functional Impairments**: (Current Impact of symptoms on functioning)

	None	Mild	Moderate	Severe	Response to Treatment*	Description
Social	☐	☐	☐	☐	_____	_____
Psychological	☐	☐	☐	☐	_____	_____
Physical Health / Self Care	☐	☐	☐	☐	_____	_____
Work/school	☐	☐	☐	☐	_____	_____

*Response to Treatment: (I) Improving, (NC) No Change, (D) Declining

4. **Is patient taking psychotropic medication(s)?** ☐ Yes ☐ No ☐ Not Recommended ☐ Patient Declined
   If yes, please describe: ☐ anti-depressant ☐ mood stabilizer ☐ anti-anxiety ☐ psycho-stimulant
   ☐ anti-psychotic ☐ other ☐ don't know
   If patient is taking medications, who is prescribing them? ☐ Psychiatrist ☐ ARNP ☐ Primary Care Physician
   Other _____ Name of Provider _____
   Have you communicated with: Patient's Treating Prescriber? ☐ Yes ☐ No ☐ N/A

5. **Have you communicated with the Patient's Primary Care Physician?** ☐ Yes ☐ No

6. **Current Frequency of Visits**: ☐ Once/week ☐ Twice/month ☐ Once/month ☐ Other _____
   Planned Frequency of Visits: ☐ Once/week ☐ Twice/month ☐ Once/month ☐ Other _____

7. **Number & Type (CPT Codes) of Additional Sessions Requested for the next 12 months** _____

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Treatment Plan

Please Note: In order for GHC to authorize continuing mental health care, treatment needs to be medically necessary, as determined by review of clinical and treatment information provided/available and Medical Necessity Criteria.

Primary Diagnosis: _____ **Code:** _____ ☐ DSM ☐ ICD-10

Outline or Describe Associated Symptoms being treated: _____

Duration of Symptoms being treated: ☐ <30 Days ☐ 1-6 Months ☐ 7-12 Months ☐ >1 Year

Current Symptom Severity: ☐ None ☐ Mild ☐ Mild-Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

Goal (Specific, Measurable): _____

As Measured by: _____

Treatment Modality: ☐ Med Mngmt ☐ CBT ☐ DBT ☐ IPT ☐ Other _____

Current Treatment Interventions to Meet Goal (Specific; Frequency and Duration) _____

Outline Progress towards goal (including any changes in symptoms and response to treatment as measured by the method outlined above) _____

Current Status: ☐Resolved ☐Significant Progress ☐Moderate Progress ☐Little Progress ☐No Progress ☐Declining

If patient is not progressing toward meeting therapeutic goals:

1. Describe reason for lack of progress: _____

2. What changes in treatment (Treatment Modality, Specific, Measurable Goals and Interventions) are being made to help patient progress in treatment? _____

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Secondary Diagnosis: _____ **Code:** _____ ☐ DSM ☐ ICD-10

Outline or Describe Associated Symptoms being treated: _____

_____

_____

Duration of Symptoms being treated: ☐ <30 Days ☐ 1-6 Months ☐ 7-12 Months ☐ >1 Year

Current Symptom Severity: ☐ None ☐ Mild ☐ Mild-Mod ☐ Moderate ☐ Mod-Severe ☐ Severe

Goal (Specific, Measurable): _____

_____

_____

As Measured by: _____

_____

Treatment Modality: ☐ Med Mngmt ☐ CBT ☐ DBT ☐ IPT ☐ Other_____

Current Treatment Interventions to Meet Goal (Specific; Frequency and Duration) _____

_____

_____

_____

Outline Progress towards goal (including any changes in symptoms and response to treatment as measured by the method outlined above) _____

_____

_____

_____

Current Status: ☐Resolved ☐Significant Progress ☐Moderate Progress ☐Little Progress ☐No Progress ☐Declining

If patient is not progressing toward meeting therapeutic goals:

1. Describe reason for lack of progress: _____

_____

_____

2. What changes in treatment (Treatment Modality, Specific, Measurable Goals and Interventions) are being made to help patient progress in treatment? _____

_____

_____

_____

Person Completing Form: _____ _____

Name, Title (print) Signature

If additional space is required, please attach an addendum

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