AmeriHealth Caritas District of Columbia

Outpatient Treatment Request (OTR)

Please print clearly – incomplete or illegible forms will delay processing. Please return to AmeriHealth Caritas District of Columbia (DC) via fax to **1-855-410-6638**. For assistance, contact **1-800-408-7510**.

1. Member information

Member name: _____ Medicaid number: _____ SSN: _____ DOB: _____

Member address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Who referred member for treatment?

☐ Self/parent ☐ Primary care provider (PCP) ☐ School ☐ State agency: _____ ☐ Other: _____

Name of referring agent: _____ Phone: _____

2. Treating provider information

Name: _____ ☐ MD ☐ Licensed ☐ Licensed clinician

National provider ID number: _____ ☐ PAR ☐ Non-PAR ☐ In credentialing process

Address: _____

City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____

Group name/AmeriHealth Caritas DC ID number: _____

Contact name: _____ Treating provider signature: _____

3. Reason for services

Primary reason/complaint: _____ Start date requested: _____

Services requested: _____ Service code(s): _____ Frequency: _____

4. DSM diagnosis

List all DSM diagnoses (behavioral and medical):

5. Please answer the following questions

a) Is the member currently participating in any school services? ☐ Yes ☐ No

b) Is the member's family or supports involved in treatment? ☐ Yes ☐ No

c) Has the member been evaluated by a psychiatrist? ☐ Yes ☐ No

d) Is the member involved with Juvenile Justice or DCYS? ☐ Yes ☐ No

e) Is there coordination of care with other behavioral health providers? ☐ Yes ☐ No

f) Is there coordination of care with medical providers? ☐ Yes ☐ No

6. Reason for authorization of non-PAR providers

(Utilization Management will contact provider directly before giving authorization.)

☐ N/A – provider is PAR.

a) Specialty of provider to meet the needs of the member: _____

b) Continuity of care concerns: _____

c) Accessibility/availability of provider: _____

d) Clinical rationale: _____

7. Medications

Is member on prescribed medication(s)? ☐ Yes ☐ No Prescribing physician(s) name(s): _____

Is member compliant with medication(s)? ☐ Yes ☐ No Please list medications and dosages: _____

8. Treatment plan

Please attach the current treatment plan.
Please include documentation related to progress on goals and any changes made as a result.

9. Additional comments

Submit to:
AmeriHealth Caritas DC Utilization Management
Fax: **1-855-410-6638**
For assistance, please call **1-800-408-7510**.

WE ARE WASHINGTON DC GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR

DHCF This program is funded in part by the Government of the District of Columbia Department of Health Care Finance.

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