The Holman Group
Managed Behavioral Health Care Services

Assessment/Request for Treatment Follow-Up Authorization

(For initial MD visit only)

Patient: ______________________ Insured: ______________________

Insured's Social Security #: ______________________ Relationship: ______________________

Employer/Union: ______________________

Date of Birth: __________ Age: ______ Patient's Phone #: ______________________

Provider/Facility: ______________________ Phone #: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: ______________

MENTAL STATUS EXAM (PLEASE CHECK APPROPRIATE BOX FOR EACH CATEGORY):

Orientation:	☐ Intact	☐ Impaired:	☐ Date	☐ Place	☐ Time	☐ Situation
Appearance:	☐ Well-groomed	☐ Disheveled	☐ Bizarre	☐ Inappropriate		
Motor Activity:	☐ Calm	☐ Hyperactive	☐ Agitated	☐ Tremors/Tics	☐ Muscle Spasms	
Speech:	☐ Normal	☐ Slowed	☐ Pressured	☐ Slurred	☐ Stuttering	
Thought Process:	☐ Intact	☐ Circumstantial	☐ Tangential	☐ Flight of Ideas	☐ Loose Associations	☐ Confused
Mood:	☐ Normal	☐ Depressed	☐ Anxious	☐ Euphoric		
Affect:	☐ Appropriate	☐ Labile	☐ Expansive	☐ Constricted	☐ Blunted	
Hallucinations:	☐ None	☐ Auditory	☐ Visual	☐ Olfactory	☐ Command	
Delusions:	☐ None	☐ Persecutory	☐ Grandiose			
Memory:	☐ Intact	☐ Impaired:	☐ Immediate	☐ Recent	☐ Remote	
Judgement:	☐ Intact	☐ Impaired:	☐ Mild	☐ Moderate	☐ Severe	

DSM IV Dx:

I .______.____ ______.____ II .______.____ ______.____ III .______________________

IV. ______________________ V. Current __________ Past year __________

Medical History: ______________________

Mental Health/Treatment History: ______________________

Substance Abuse use and History: ______________________

Medication History: ______________________

Medications, dosage, frequency, start date: ______________________

Received informed consent for medication: ☐ Yes ☐ No ☐ N/A Any allergies?: ☐ Yes ☐ No

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List all dates of service utilized during and beyond the current authorization period (specific dates): ____________________

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Type of treatment requested: Medication Mgt.

☐ 90862 - Limited Follow-up ☐ 90805-Med. Mgt. w/Therapy ☐ Other: ____________________

Dates Requesting: From ______________ To ______________ Frequency _______ wk ______ mo ______ yr _______

Brief narrative of patient's current complaints and coping strategies: ____________________

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____

Drug & Alcohol current use and history

☐ None ☐ Use ☐ Dependence ☐ Inpatient Treatment ______ ☐ Outpatient Treatment ________ ☐ 12 Step ___________

Substance(s)	Quantity	Frequency	Date of last use	Duration of use	Number of attempts at sobriety	Type CD treatment

Treatment Plan:

Current Symptom (i.e., sleep disturbance, poor concentration, decreased appetite, etc.)	**Intervention** (i.e., medication management, cognitive restructuring, guided imagery, reframing, etc.)	**Target Date**	**Estimated Termination Date**
1.	1.		
2.	2.		
3.	3.		
4.	4.		

Use of adjunctive therapies: outpatient therapy, self-help programs, etc. (e.g., Alcoholics Anonymous):

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Recommended Referrals: ____________________

To request referrals under the patient's mental health benefits please call (800) 321-2843.

If applicable, I have coordinated care with other treating providers: **YES** ☐ **NO** ☐ **N/A** ☐

I certify that the above is true and correct:

Provider's Signature: ______________________________ Date: ______________

Authorization is hereby given to Provider to release to The Holman Group any information which he/she deems necessary to evaluate for insurance purposes.

Signature of Patient, Parent or Guardian: ______________________________ Date: ______________

(Signature on file is not acceptable) If any information is omitted, this form will be returned to the Provider.

For The Holman Group Use Only:

Number of Sessions/Days: ____________________

Level: Individual ___ Conjoint ___ Group ___ Other___

Dates: From ____________________ To ____________________ Initialed ______

The Holman Group Care Management Department recommends a referral to: ____________________

C.M./U.M.C. Notes: ____________________

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