Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) Outpatient Treatment Request (OTR)

Today's date: **Admit date:**

This service requires prior authorization; authorizations will not be backdated.

Member information			
Name:			
DOB:		Medicaid/Member ID #:	
Address:			
City:	State:	ZIP:	Phone:
Legal guardian (if applicable):			
If under age 21, currently enrolled in Coordinated System of Care (CSOC)? ☐ Yes ☐ No If yes, please direct this request to Magellan.			
Currently enrolled in assertive community treatment (ACT)? ☐ Yes ☐ No		ICD-10 code:	
Primary DSM diagnosis code:			

Group information		
Group/Agency name:		
Address:		
City:	State:	ZIP:
Phone number:	Fax number:	
TIN #:	NPI #:	
Contact name:		
Contact phone:	Contact email	

Current treatment request — CPST	
HCPCS code: ☐ H0036	Frequency (# times per week):
Service start date:	Total number of units:
All service requests will be authorized for 6 months:	
Is this a request for Permanent Supportive Housing (PSH) (TG modifier)? ☐ Yes ☐ No	

Current treatment request — PSR	
HCPCS code: ☐ H207	Frequency (# times per week):
Service start date:	Total number of units:
All service requests will be authorized for 6 months:	
Is this a PSH request (TG modifier)? ☐ Yes ☐ No	

Level of member's impairment:	☐ No Impairment	☐ Mild	☐ Moderate	☐ Severe
Progress since last review:	☐ No Impairment ☐ Very much improved	☐ Minimally improved ☐ Initial request, not applicable	☐ Much improved	

Member name:	Member DOB:
For continued stay requests, please describe, for **last 30 days,** functional impairment and engagement level in treatment (optional):	
Current symptoms that are the focus of current treatment (optional):	
Functional impairment (optional):	
Progress (optional):	
Printed name and credentials of licensed mental health provider (LMHP)/provider:	
Signature of LMHP/provider:	
Submitted by:	Submitted by:

Member name:	Member DOB:

Please submit this form with the following items:	
For under age 21:	
☐	CALOCUS/LOCUS (for 6 years and up) scoresheet signed by a Licensed Mental Health Professional (LMHP), updated every 180 days, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date
☐	Assessment, signed by an LMHP, updated every 180 days
☐	Treatment plan, signed by an LMHP, updated every 180 days, including a crisis mitigation plan
☐	Signed Freedom of Choice form (only with initial request or a change in provider)
☐	Progress summaries (submitted for concurrent reviews only)
For age 21 and over:	
☐	LOCUS scoresheet signed by an LMHP updated every 365 days, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date
☐	Assessment signed by an LMHP, updated every 365 days
☐	Treatment plan signed by an LMHP, updated every 180 days, including a crisis mitigation plan
☐	Signed Freedom of Choice form (only with initial request or a change in provider)
☐	Progress summaries (submitted for concurrent reviews only)