

A UnitedHealthcare Company





OUTPATIENT TREATMENT REQUEST FORM (OTR)						
Fax Request To: HPN BH, Utilization Management, 702-341-7681			Questions/Concerns: 702-240-8733 or 877-399-6094			
*Please allow 14 days for processing request. You may verify the status of your request via online provider center.*						
Instructions:			All sections marked with an asterisk (*) must be completed. Lack of information will delay the process of this form.			
Member Information						
*Member Name:			*Member ID Number:			
*Date of Birth:			*Insurance Plan:			
		er Information	Information			
*Group/Facility Name:						
*Rendering Provider Name and Title:						
*If applicable, Supervising Provider Name and Title:						
NPI for the Provider:			*Tax ID:			
*Address:		*City:	*State and Zip:		Zip:	
*Telephone #:			Fax #:			
Requested Services						
Select One: Psychotherapy Medication Management – Office visit Substance Use Disorder   Specialty Injectables – Sublocade and/or Vivitrol only *CPT required below. Long acting injectables (LAI are a pharmacy benefit. If you're requesting LAIs, click Behavioral Health Injectable Antipsychotic PA Form or go to https://www.healthplanofnevada.com/Provider/Long-Acting-Injectable-Medications.						
Select One:	Initial Service Request		Additional Services Request			
Initial Services Request – End date is determined by one (1) calendar year from start date.						
Additional Services Request – Clinically reviewed. End date is determined by frequency of sessions.						
Select One For Initial 1 - 90791 (Psychotherapy/Substance Use Disorder) 1 - 90792 (Medication   Services Only: Management)   I - H0001 - HF (Alcohol and/or Drug Assessment) (Medicaid only)					2 (Medication	
*Start Date of Requesting Service: *Diagnosis:						
*SERVICES REQUESTED:						
CPT Code Requested:	Number of	Session	s: Frequ	iency of Sessio	ns:	
CPT Code Requested:	Number of Sessions		s: Frequ	Frequency of Sessions:		
CPT Code Requested:	Number of Session		s: Frequ	Frequency of Sessions:		
CPT Code Requested:	Number of Session		s: Frequ	iency of Sessio	ns:	
CPT Code Requested:	Number of Session		s: Frequ	Frequency of Sessions:		
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CONFIDENTIALITY NOTICE

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Meml	ber Information					
*Member Name:	*Member ID Number:					
*Date of Birth:	*Insurance Plan:					
Treatment Information						
Prior Treatment:	Yes No					
Explain:						
Explain: Presenting/Current Symptoms, Impairment of Fun	iction and/or Any Progress to Date:					
*For SUD cases, please provide ASAM dimensions (1-6)						
Interventions and Goals:						
LOCUS Score: CALOCUS-CASII	Score: ESCII Score:					
Signature of Rendering Provider:						
*If Applicable, Signature Supervising Provider:						

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