

For timely processing of your request, please fill out all sections of this form completely

## REGENCE BEHAVIORAL HEALTH TREATMENT PLAN REQUEST FORM

Confidential Information

<b>Patient Name:</b> _____	<b>Patient ID:</b> _____	<b>DOB:</b> _____	<b>Gender:</b> M / F
<b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced	<b>Number of Dependents:</b> _____	<b>Employment Status:</b> _____	
<b>Provider Name:</b> _____	<b>Provider ID/Rider #:</b> _____		
<b>Provider Phone #:</b> _____	<b>Service Address:</b> _____		
<b>Health/Benefit Plan:</b> <input type="checkbox"/> FEP <input type="checkbox"/> PEBB-OR <input type="checkbox"/> RBCBS-OR <input type="checkbox"/> RBS-WA <input type="checkbox"/> RBCBS-UT <input type="checkbox"/> RBS-ID Other: _____			

**I. Diagnosis – Use DSM-IV, Include All Axes:**  
**Axis I:** \_\_\_\_\_  
**Axis II (Personality):** \_\_\_\_\_  
**Axis III (Medical conditions):** \_\_\_\_\_  
**Axis IV (Stressors):** \_\_\_\_\_  
**Axis V (GAF) Current:** \_\_\_\_\_ **Highest in the last 12 months:** \_\_\_\_\_

**II. Current Risk Factors:**  
**Suicidal/Homicidal Ideation:** (None) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 (Severe)  Safety plan in place  
**Substance Abuse:**  None  Remission  Unstable Remission  Abuse  Dependence  Under evaluation

**III. Treatment Information – Current Episode:**  
**First date of service:** \_\_\_\_\_ **First date of service this year:** \_\_\_\_\_  
**# of sessions to date:** 90801 \_\_\_\_\_ 90806 \_\_\_\_\_ 90847 \_\_\_\_\_ 90853 \_\_\_\_\_ 90862 \_\_\_\_\_ Other: \_\_\_\_\_  
**# of sessions requested:** 90801 \_\_\_\_\_ 90806 \_\_\_\_\_ 90847 \_\_\_\_\_ 90853 \_\_\_\_\_ 90862 \_\_\_\_\_ Other: \_\_\_\_\_  
**Current frequency:** \_\_\_\_\_ **Frequency requested:** \_\_\_\_\_  
**# of sessions to termination of current episode of treatment (estimated):** \_\_\_\_\_  
**Treatment orientation:**  Cognitive/behavioral  Family systems  Psychodynamic  Other \_\_\_\_\_  
**Have you coordinated care with: PCP**  Yes  No **Other providers or medication prescribers**  Yes  No

**IV. Medications:**  
**Current (dosage and length of time on medication):** \_\_\_\_\_  
**Prescribed by:**  PCP  PMHNP/ARNP  Psychiatrist

**Presenting Symptoms and Related History:**

  
  
  
  
  
  
  
  
  
  

<b>Treatment Goals (behaviorally defined):</b>	<b>Progress Made Toward Each Goal:</b>

**Termination Criteria (briefly describe termination criteria; observable, measurable and related to symptoms):**

  
  
  
  
  
  
  
  
  
  

Signature: \_\_\_\_\_ Licensure: \_\_\_\_\_ Date: \_\_\_\_\_

- Fax the completed treatment plan to Regence Behavioral Health at 1 (800) 331-3505
- Or mail this request to:  
Regence Behavioral Health  
PO Box 1271, Mailstop E9H  
Portland, OR 97207-9861
- For treatment plan authorization questions only, please call Behavioral Health Customer Service 1 (800) 780-7881