

*** Illegible ARFs will be returned without being authorized ***

Type of Service Requested: Mental Health Substance Abuse

Client Demographics:

Client’s Name (please print):

 Last First Middle Initial

Client’s D.O.B: ____/____/____ Social Security #: _____-_____-_____

Client’s OPC Medical Record #: _____ Medicaid ID #: _____

Client’s County of Residence: _____

Financial Information:

Private Insurance Medicare Health Choice Medicaid IPRS
 Have efforts been made to seek entitlements (Medicaid, SSI, HealthChoice, etc.)?: Yes No. If “Yes”, then pending denied other – explain: _____
 _____ If “No”, please explain: _____

Current Risk Assessment: (Please select/circle one rating for each type of risk.)

Key: 0 = none, 1 = ideation only; 2 = moderate, ideation with EITHER plan or history of attempts;
 3 = severe, ideation AND plan, with intent or means; na = not assessed

- Client’s risk to self: 0 1 2 3 na
- Client’s risk to others: 0 1 2 3 na

Current Impairments: (Please select/circle one value for each type of impairment)

Key: 0 = none, 1 = mild or mildly incapacitating, 2 = moderate or moderately incapacitating,
 3 = severe or severely incapacitating, na = not assessed for this impairment

- Mood Disturbances (Depression or Mania) 0 1 2 3 na
 - Anxiety 0 1 2 3 na
 - Psychosis/Hallucinations/Delusions 0 1 2 3 na
 - Thinking/Cognition/Memory/Concentration 0 1 2 3 na
 - Impulse/Reckless/Aggressive Behavior 0 1 2 3 na
 - Activities of Daily Living Problems 0 1 2 3 na
 - Substance Abuse/Dependence 0 1 2 3 na
- Select all that apply:* Alcohol Illegal drugs Prescription drugs
- Medical/Physical Conditions (list on Axis III) 0 1 2 3 na
 - Job/School Performance Problems 0 1 2 3 na
 - Social/Relationships/Marital/Family Problems 0 1 2 3 na
 - Legal Problems 0 1 2 3 na

ASAM Dimensions: (Required when consumer has substance abuse/dependence diagnosis)

- 1: Intoxicated/WD Potential Lo Med Hi 4: Readiness to Change Lo Med Hi
- 2: Biomedical Conditions Lo Med Hi 5: Relapse Potential Lo Med Hi
- 3: Emot/Beh/Cog Conditions Lo Med Hi 6: Recovery Environ. Lo Med Hi

Also Complete The Boxed Section Below:

Treatment History: (Please select all that apply)

Psychiatric Treatment in the Past 12 Months: None Unknown
 Outpatient Partial Hosp. Inpatient Residential Group Home
Outcome: Unknown Improved No Change Worse

Treatment Compliance (Non-medication): Unknown poor fair good

Substance Abuse Treatment in Past 12 Months: None Unknown
 Outpatient Intensive IOP Inpatient Residential Group Home
Outcome: Unknown Improved No change Worse

Treatment Compliance (Non-Medication): Unknown poor fair good

Reason for continued treatment: (Please select all that apply) Remains symptomatic
 Prepare for discharge from inpt/residential/group home within coming month
 Prepare for discharge from all treatment within coming month Maintenance
 Other _____

Services currently and/or recently received: (Attach additional pages if needed)

- Service: _____ Frequency: _____
- Service: _____ Frequency: _____
- Service: _____ Frequency: _____
- Service: _____ Frequency: _____
- Service: _____ Frequency: _____
- Service: _____ Frequency: _____

Current Psychotropic Medications: (May attach medication list or additional page) **Usually Adherent?**

- 1. _____ Yes No
- 2. _____ Yes No
- 3. _____ Yes No
- 4. _____ Yes No
- 5. _____ Yes No
- 6. _____ Yes No
- 7. _____ Yes No

Client's Name (please print):

_____ OPC Medical Record #: _____ Medicaid ID #: _____
Last First Middle Initial

Provider Demographics:

Name of Requestor: _____ Position: _____ Email Address (Optional): _____

Provider/Agency _____

Phone #: _____ Fax #: _____

Level of Care : A B C D E

Diagnoses: (Include BOTH the codes AND the written out diagnoses for Axis I & II)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF = _____ Highest GAF in past year = _____

Target Populations (all eligible): _____

Are the client's family/supports involved in treatment? Yes No

Coordination of care with other behavioral health providers? Yes No

Coordination of care with medical providers? Yes No

Has client been evaluated by a Psychiatrist? Yes No

SERVICE AUTHORIZATION REQUEST

Requested Start Date: ____/____/____

Provider Agency (& Location or Program)	Service	Code	Service Unit	# Units / Day, Wk. Mo.
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____
_____	_____	_____	_____	____/____/____

LME USE ONLY – Authorization Approval		
# Units	Start Date	Expired Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Comments: _____

OPC Care Management FAX: (919) 913-4004

Signature of Requestor Date

Signature of LME Authorizer Date