

OUTPATIENT TREATMENT REQUEST

(OTR) Effective 01/01/2011



BlueCross BlueShield
of New Mexico

Instructions: Please fill out and print, or print form and fill out legibly in black ink. Fax to BCBSNM at 877-361-7659. All fields in shaded areas are mandatory.

Patient/Member Information

Patient Name _____ Member Name _____
Patient DOB _____ Group # _____
Subscriber # _____

Provider Information (Individual and/or Group)

Provider Name _____ Address _____
City _____ State _____ Zip _____
NPI # _____ Fax # _____ Phone # _____

Has the member been screened for possible substance use disorder? Yes No

DSM-IV or ICD-9 Diagnosis *numeric and description*

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V Current _____ Highest Past Year _____

Primary Diagnosis

Targeted Symptoms of Treatment:

Current Treatment

Stage of Therapy: (Check one)

Initiation Continuation Maintenance

Type of Psychotherapy

- Cognitive Behavioral
 Dialectical Behavioral
 EMDR
 Interpersonal
 Psychoanalytic
 Psychodynamic
 Psycho-educational
 Supportive
 Other (Specify): _____

Goals for Treatment

Goal #1: _____
Intervention for Goal #1 _____
Goal #2: _____
Intervention for Goal #2 _____
Authorization should start on: _____ (date)

Anticipated Treatment Outcome:

Discharge from Care Date: _____
 Transition to Maintenance Care Date: _____
 Other _____

The patient's care is being coordinated with the following individuals: (Check all that apply)

PCP _____ Psychiatrist _____ Other Therapist _____ Other _____

If no coordination with others, why? _____

Requested Treatment (Number and Frequency)

| Modality and CPT Code | Req | Freq |
|--|-------|-------|
| <input type="checkbox"/> 90832 Individual, 30 min | _____ | _____ |
| <input type="checkbox"/> 90833 Ind. with E/M, 30 min | _____ | _____ |
| <input type="checkbox"/> 90834 Individual, 45 min | _____ | _____ |
| <input type="checkbox"/> 90836 Ind. with E/M, 45 min | _____ | _____ |
| <input type="checkbox"/> 90837 Individual, 60 min | _____ | _____ |
| <input type="checkbox"/> 90847 Couple/Family | _____ | _____ |
| <input type="checkbox"/> 90853 Group | _____ | _____ |
| <input type="checkbox"/> Other _____ | _____ | _____ |

Current Medications

Psychiatric Meds (Name/Dose)
Is this Patient on psychotropic meds for
condition being treated? Yes No

Other Meds

Additional Clinical Information: _____

My signature confirms that I am providing the requested services:

Signature _____ Date _____



O T R