AmeriHealth Caritas
District of Columbia

Outpatient Treatment Request (OTR)

Please print clearly — incomplete or illegible forms will delay processing. Please return to AmeriHealth Caritas District of Columbia (DC) via fax at **1-855-410-6638**. For assistance, please call **1-800-408-7510**.

Enrollee information

Enrollee name: ____________________ Medicaid number: ____________ Social Security number: _

Date of birth: __________ Enrollee address: ______________________________

City: ____________________ State: _______ ZIP: ________ Phone: ______________

Who referred enrollee for treatment?

Self or guardian Primary care provider (PCP) School State agency: __________ Other: ____________

Name of referring agent: ______________________________ Phone: ______________

Treating provider information

Name: ______________________________ M.D. Licensed Licensed clinician

National provider identifier (NPI) number: ______________ In network Out of network In credentialing process

Address: ______________________________

City: ____________________ State: _______ ZIP: ________ Phone: __________ Fax: ____________

Group name or AmeriHealth Caritas DC ID number: ______________________________

Contact name: ____________________ Treating provider signature: ____________________

Reason for services

Primary reason or complaint: ____________________ Start date requested: ______________

Services requested: ________ Service codes: __________ Frequency: ______________

DSM diagnosis

List all DSM diagnoses (behavioral and medical):

Please answer the following questions

a) Is the enrollee currently participating in any school services? Yes No

b) Is the enrollee's family or supports involved in treatment? Yes No

c) Has the enrollee been evaluated by a psychiatrist? Yes No

d) Is the enrollee involved with juvenile justice or the Child and Family Services Agency (CFSA)? Yes No

e) Is there coordination of care with other behavioral health providers? Yes No

f) Is there coordination of care with medical providers? Yes No

Reason for authorization of out-of-network providers
(Utilization Management will contact provider directly before giving authorization.)

Not applicable — provider is in network.

a) Specialty of provider to meet the needs of the enrollee: ______________________________

b) Continuity of care concerns: ______________________________

c) Accessibility and availability of provider: ______________________________

d) Clinical rationale: ______________________________

Medications

Is enrollee on prescribed medications? Yes No Prescribing physicians' names: ______________

Is enrollee compliant with medications? Yes No Please list medications and dosages: ______________

Treatment plan

Please attach the current treatment plan.
Please include documentation related to progress on goals and any changes made as a result.

Additional comments

Submit to:
AmeriHealth Caritas DC Utilization Management
Fax: **1-855-410-6638**
For assistance, please call **1-800-408-7510**.