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**.

Member information

Member name: _____ Medicaid number: _____ Social Security number: _

Date of birth: _____ Member address: _____

City: _____ State: _____ ZIP: _____ Phone: _____

Who referred member 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 member currently participating in any school services? ☐ Yes ☐ No

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

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

d) Is the member 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 member: _____

b) Continuity of care concerns: _____

c) Accessibility and availability of provider: _____

d) Clinical rationale: _____

Medications

Is member on prescribed medications? ☐ Yes ☐ No Prescribing physicians' names: _____

Is member 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**.

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GOVERNMENT OF THE DISTRICT OF COLUMBIA MURIEL BOWSER, MAYOR
MEDICAID DC

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