

**Universal Care
Behavioral Health
12511 Brookhurst Street
Garden Grove, CA 92840
Telephone: 866-981-5003 Fax: 562-216-2702**

Attention Provider:

This Forms Set is to be used for the authorization that was just faxed to you:

1. Form 3202 - Initial Treatment Request & Consultation Report

- Complete this form immediately after the initial visit.
- Obtain a consent for release of information from the member giving permission to forward this information to the PCP.
- Fax this form to Universal Care Behavioral Health
- An authorization for up to 9 follow-up visits will be faxed to you.

2. Form 3201 - Continued Treatment Request & Consultation Form

- Place this form in the member's clinical file for later use.
- On or prior to the last authorized session, please complete this form.
- Fax the form to Universal Care Behavioral Health.
- An authorization for up to 10 continued treatment visits will be faxed to you.

3. Form 2817 - Discharge Summary

- Place this form in the member's clinical file for later use.
- On the last treatment session or after the patient has not been seen for 6 months, please complete this form.
- Fax the form to Universal Care Behavioral Health

Thank you for providing services to our members. Our goal is to make the authorization process as easy for our providers as humanly possible. If you have any questions please call us at 866-981-5003.

**Universal Care Behavioral Health
INITIAL TREATMENT REQUEST & CONSULTATION REPORT (#3202)**

Patient's Name: _____ DOB: _____ Member or SS #: _____ Health Plan: _____

Date of First Visit: _____ Provider: _____ Psychiatrist Psychologist LCSW MFT

Telephone: (____) _____ Fax: (____) _____

Initial Primary Diagnosis (SELECT ONE):

<input checked="" type="checkbox"/>	309.9	Adjustment disorder, unspecified	<input checked="" type="checkbox"/>	309.24	Adjustment disorder, with anxiety
	309.0	Adjustment disorder with depressed mood		309.3	Adjustment disorder with disturbance of conduct
	309.28	Adjustment disorder with mixed anxiety & depressed mood		309.4	Adjustment disorder with mixed disturbance of emotions and conduct
	305.00	Alcohol abuse		303.90	Alcohol abuse
	305.70	Amphetamine abuse		304.40	Amphetamine dependence
	307.1	Anorexia nervosa		299.80	Asperger's disorder
	314.01	Attention deficit/hyperactivity disorder, combined		314.00	ADHD, predominantly hyperactive-impulsive
	314.00	ADHD, predominantly inattentive		314.9	ADHD, NOS
	299.00	Autistic disorder		296.80	Bipolar Disorder, NOS
	296.89	Bipolar II disorder		307.51	Bulimia Nervosa
	312.80	Conduct disorder		300.11	Conversion disorder
	311	Depressive disorder, NOS		300.4	Dysthymic disorder
	300.02	Generalized anxiety disorder		312.30	Impulse control disorder, NOS
	312.34	Intermittent explosive disorder		296.31	Major Depression Recurrent, mild
	296.32	Major Depression Recurrent, moderate		296.33	Major Depression Recurrent, severe w/o psychotic features
	296.34	Major Depression Recurrent, severe w psychotic features		296.30	Major Depression Recurrent, unspecified
	296.26	Major Depression Single Episode, mild		296.25	Major Depression Single Episode, moderate
	296.23	Major Depression Single Episode, severe w/o psychotic features		296.24	Major Depression Single Episode, severe w psychotic features
	296.20	Major Depression Single Episode, unspecified		300.3	Obsessive-Compulsive Disorder
	313.81	Oppositional Defiant Disorder		300.21	Panic Disorder with Agoraphobia
	300.01	Panic Disorder without Agoraphobia		299.80	Pervasive Developmental Disorder
	309.81	Posttraumatic Stress Disorder		298.9	Psychotic Disorder, NOS
	295.70	Schizoaffective Disorder		295.20	Schizophrenia, catatonic
	295.10	Schizophrenia, disorganized		295.30	Schizophrenia, paranoid
	295.60	Schizophrenia, residual		295.90	Schizophrenia, undifferentiated
	309.21	Separation Anxiety Disorder		300.29	Specific Phobia

Other: _____ DSM IV Code: _____

Risk Factors: None Danger to Self Danger to Others Child/Adolescent – Danger of Removal From Home

Number of Months Symptoms Have Been Present: _____ Number of Months Symptoms Would Last Without Treatment: _____

Area(s) of Impairment: Self-care (_Mild_Moderate_Severe) Work/School (_Mild_Moderate_Severe)
 Home/Family (_Mild_Moderate_Severe) Community (_Mild_Moderate_Severe)

For Children/Adolescents: Enrolled in Special Education Program No Yes Unknown

Current Global Assessment of Functioning (GAF) Score _____ Highest GAF Score Past Year _____ (Low 10 - High 100)

Recommendations: No Follow-up Needed Refer for Medication Evaluation Refer for Psychotherapy
 Follow Treatment Plan:

Primary Mode of Treatment: (90862) Medication Monitoring (90807/05) Psychotherapy with Medication Monitoring
 (90806/04) Individual Psychotherapy (90847) Family Therapy (90853) Group Therapy
 Other: _____

Number of sessions requested and type (90862, 90807, 90806, 90847, etc.). UP TO A TOTAL OF 9 SESSIONS ONLY:

CPT Code: _____ Frequency: _____ CPT Code: _____ Frequency: _____ CPT Code: _____ Frequency: _____

Medications: Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

Provider Signature Date Telephone

[Member has signed release of information to PCP and this form may be forwarded to PCP Yes No Initials _____]

Please Fax Completed Forms To (562) 216-2702

Universal Care Behavioral Health

CONTINUED TREATMENT & CONSULTATION REPORT (#3201)

Patient Name: _____ DOB: _____ Member or SS #: _____

Insurance Company: _____ Medical Group: _____ Group Number: _____

Provider: _____ Telephone: _____ Fax: _____

Previous Authorization Number: _____ Total Sessions Completed: _____ Date of Last Visit: _____

Primary Diagnosis: _____ Code: _____

Secondary Diagnosis: _____ Code: _____

Current Global Assessment of Functioning (GAF) Score _____ Highest GAF Score Past Year _____
(Low 10 - High 100)

RISK FACTORS: None

Danger to Self: _____

Danger to Others: _____

Child/Adolescent – Danger of Removal From Home: _____

AREA(S) OF IMPAIRMENT:

Self-care: _____

Severity: Mild Moderate Severe

Treatment Goal(s): _____

Work/School: _____

Severity: Mild Moderate Severe

Treatment Goal(s): _____

Home/Family: _____

Severity: Mild Moderate Severe

Treatment Goal(s): _____

Community: _____

Severity: Mild Moderate Severe

Treatment Goal(s): _____

For Children/Adolescents: Enrolled in Special Education Program No Yes _____

Primary Mode of Treatment:

(90862) Medication Monitoring # Sessions Requested _____ Frequency _____

(90807/05) Psychotherapy with Medication Monitoring # Sessions Requested _____ Frequency _____

(90806/04) Individual Psychotherapy # Sessions Requested _____ Frequency _____

(90847) Family Therapy # Sessions Requested _____ Frequency _____

(90853) Group Therapy # Sessions Requested _____ Frequency _____

Other: _____ # Sessions Requested _____ Frequency _____

Medications: Name: _____ Dosage: _____

Name: _____ Dosage: _____

Provider Signature Date Telephone

[Member has signed release of information to PCP and this form may be forwarded to PCP Yes No Initials _____]

Please Fax Completed Forms To (562) 216-2702

**Universal Care Behavioral Health
DISCHARGE SUMMARY (#2817)**

Out Patient Admission Date: _____ **Discharge Date*:** _____

Presenting Information: _____

Services Received and Response: _____

Medication(s): (Include Dosage & Response) None _____

Disposition and Recommendations: If referred, include name of agency(s) or practitioner(s)

Referral Out Code: _____

Diagnosis: (Circle One)

Axis I	Prin/Sec _____	Code _____
	Prin/Sec _____	Code _____
Axis II	Prin/Sec _____	Code _____
Axis III		Code _____
Axis V	Discharge GAF _____	Prognosis _____

 Signature & Discipline _____ Date _____

* Discharge Date: Last service date, or, last cancelled, or last missed appointment date

This confidential information is provided to you in accordance with applicable Welfare and Institutions Code Sections. Duplication of this Information for further disclosure is prohibited without the prior written consent of the patient/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.	Name: _____ DOB: _____ MR# _____
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[Member has signed release of information to PCP and this form may be forwarded to PCP Yes No Initials _____]

Please Fax Completed Forms To (562) 216-2702