



BEHAVIORAL HEALTHCARE OPTIONS, INC.SM
SUBSTANCE ABUSE OUTPATIENT TREATMENT REQUEST FORM (OTR)

Fax request to: BHO, Utilization Management, 702-341-7681	Phone requests or Questions? 702-364-1484 or 800-873-2246
<input type="checkbox"/> 1- H0001-HF Alcohol And/ Or Drug Assessment	Beginning Date of Service: <input style="width: 50px;" type="text"/>

INITIAL SERVICES REQUESTED:

H0002-HF Behavioral Health Screening to determine eligibility for admission to treatment program
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

H0005-HF Alcohol &/or Drug Services; Group Counseling
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

H0007-HF Alcohol &/ or Drug Services; Crisis Intervention Outpatient
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

90834-HF Psychotherapy, 45-50 minutes with patient &/or Family Member
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

New Request for Additional sessions—clinically reviewed; end date is determined by frequency of sessions.
Requests for additional services MUST be submitted by fax using this form.

REQUESTED ADDITIONAL SERVICES:

H0002-HF Behavioral Health Screening to determine eligibility for admission to treatment program
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

H0005-HF Alcohol &/or Drug Services; Group Counseling
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

H0007-HF Alcohol &/ or Drug Services; Crisis Intervention Outpatient
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

90834-HF Psychotherapy, 45-50 minutes with patient &/or Family Member
 Number of Sessions: DOS: to FREQUENCY OF SESSIONS:

MEMBER/PATIENT INFORMATION

Reference Number of Initial Request (if applicable):

Member ID number:

Member Name (last, first, middle initial): Date of Birth:

PROVIDER INFORMATION

Provider Name: Provider Telephone: Provider Fax:

TREATMENT INFORMATION

PROGRESS TO DATE:

CURRENT SYMPTOMS:

PLANNED INTERVENTIONS: (If requesting code + code include clinical justification)

DSM 5 DIAGNOSIS

Axis I:

Printed Name of Clinician/Doctor:

Signature of Clinician/Doctor:

CONFIDENTIALITY NOTICE

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