Maryland Uniform Treatment Plan Form

EVERNORTH℠

For Behavioral Providers

To file electronically, providers in Maryland must register for access to the online prior authorization tool:

To file via facsimile send to:
866.217.6837

This form must be used when treatment is rendered in Maryland.
To ensure we have all the information needed to begin processing this request, please include both the customer's first and last name in the field labeled PATIENT'S FIRST NAME.

To initiate registration, send an email to PMAC@Cigna.com and include the following information:

- **Provider or facility name**
- **Mailing address**
- **Email address**
- **Contact name**
- **Contact telephone number**

Please complete this form in its entirety and fax to 866.217.6837

CLEAR FORM

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

Today's Date **01/23/2024**

Carrier or Appropriate Recipient:

PATIENT INFORMATION

PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH ____/____/____

MEMBERSHIP NUMBER

AUTHORIZATION NUMBER (If Applicable)

PRACTITIONER INFORMATION

PRACTITIONER ID# or TAX ID

PHONE NUMBER

PRACTITIONER/FACILITY NAME, ADDRESS, FAX AND PHONE

Date Patient First Seen For This Episode Of Treatment ____/____/_____

Level of care being requested: Please specify benefit type:

☐ Mental Health ☐ Substance Use Disorder ☐ Outpatient ☐ Intensive Outpatient Program ☐ Partial Hospitalization Program
☐ Acute IP ☐ IP Rehab ☐ Acute IP Detox ☐ Residential ☐ ECT ☐ rTMS ☐ Applied Behavior Analysis (ABA) ☐ Psychological Testing ☐ BioFeedback ☐ Telehealth ☐ Other _____

Primary Dx Code: _____ **Secondary Dx Code(s):** _____

Current Treatment Modalities: (check all that apply)

Psychotherapy: ☐ Behavioral ☐ CBT ☐ DBT ☐ Exposure ☐ Supportive Therapy ☐ Problem Focused ☐ Interpersonal ☐ Psychodynamic ☐ EMDR ☐ Group ☐ Couples ☐ Family ☐ Other _____

☐ **Medical Evaluation and Management**

Type of Medications (if not applicable, no response is required):

☐ Antipsychotic ☐ Anxiolytic ☐ Antidepressant ☐ Stimulant ☐ Injectables ☐ Hypnotic ☐ Non-psychotropic ☐ Mood Stabilizer ☐ Other _____

Current Symptoms and Functional Impairments: Rate the patient's current status on these symptoms/functional impairments, if applicable.

	Current Ideation	Current Plan	Prior Attempt	None
Suicidal	☐	☐	☐	☐
Homicidal	☐	☐	☐	☐

Symptoms/ Functional Impairments	None	Mild	Moderate	Severe
Self-Injurious Behavior	☐	☐	☐	☐
Substance Use Problems	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Agitated/aggressive Behavior	☐	☐	☐	☐
Mood Instability	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Cognitive Impairment	☐	☐	☐	☐
Eating Disorder Symptoms	☐	☐	☐	☐
Social/ Familial/School/WorkProblems	☐	☐	☐	☐
ADL Problems	☐	☐	☐	☐

If requesting additional outpatient care for a patient, why does the patient require further outpatient care: ☐ Maintenance treatment for a chronic condition ☐ Consolidate treatment gains ☐ Continued impairment in functioning ☐ Significant regression ☐ New symptoms and/or impairments ☐ Supportive treatment due to other treatment plan changes ☐ complex psychiatric and medical co-morbidity ☐ Complex Psychiatric and Substance abuse Co-morbidity
☐ Other _____

Signature of Practitioner: _____ Date: ____/____/_____

My signature attests that I have a current valid license in the state to provide the requested services.

Please complete this form in its entirety and fax to 866.217.6837

Complete the following if the request is for ECT or rTMS: Provide clinical rationale including medical suitability and history of failed treatments:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following for Applied Behavior Analysis (ABA) Requests(if the carrier classifies ABA as a mental health benefit):

Supervising BCBA Name _____ Has Autism Spectrum Disorder been validated by MD/DO or Psychologist? ☐ Yes ☐ No

For initial requests, what are specific ABA treatment goals for the patient?

1. _____
2. _____
3. _____

Date of Evaluation by MD/DO: _____

For continuing requests, assessment of functioning (observed via FBA, ABLLS, VB-MAPP, etc.) related to ASD including progress over the last year:

_____

For continuing requests what are the treatment goals and targeted behaviors, indicating new or continued, with documentation of progress and child's response to treatment:

1. _____
2. _____
3. _____

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Psychological Testing:

Symptoms/Impairment related to need for testing:

- ☐ Acute change in functioning from the individual's previous level
- ☐ Peculiar behaviors and/or thought process
- ☐ Symptoms of psychosis
- ☐ Attention problems
- ☐ Development delay
- ☐ Learning difficulties
- ☐ Emotional problems
- ☐ Relationship issues
- ☐ Other _____
- ☐ Personality problems
- ☐ School problems
- ☐ Family issues
- ☐ Cognitive impairment
- ☐ Mood Related Issues
- ☐ Neurological difficulties
- ☐ Physical/medical signs

Purpose of Psychological Testing:

- ☐ Differential diagnostic clarification
- ☐ Help formulate/reformulate effective treatment plan.
- ☐ Therapeutic response is significantly different from that expected based on the treatment plan.
- ☐ Evaluation of functional ability to participate in health care treatment.
- ☐ Other: (describe) _____

Substance use in last 30 days: ☐ Yes ☐ No Diagnostic Assessment Completed: ☐ Yes Date: ___/___/_____ ☐ No

Patient substance free for last ten days ☐ Yes ☐ No

Has the patient had known prior testing of this type within the past 12 months? ☐ Yes ☐ No

If so, why necessary now? ☐ Unexpected change in symptoms ☐ Evaluate response to treatment ☐ Assess functioning ☐ Other

Names and Number of Hours of each requested test _____

If appropriate, complete this section: Reason(s) why assessment will require more time relative to test standardization samples?

☐ Depressed mood	☐ Vegetative Symptom	☐ Processing speed	☐ Performance Anxiety	☐ Expressive/Receptive Communication Difficulties
☐ Low frustration tolerance	☐ Suspected or Confirmed grapho-motor deficits	☐ Physical Symptoms or Conditions such as:	☐ Other:	

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Biofeedback:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Complete the following if the request is for Telehealth:

Requested Revenue/HCPC/CPT Code(s) _____ Number of Units for each _____

Patient Membership Number _____

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Complete for Higher Level of Care Requests (e.g. inpatient, residential, intensive outpatient and partial hospitalization):

Primary reason for request or admission: (check one) ☐ Self/Other Lethality Issues ☐ Violent, unpredictable/uncontrolled behavior

☐ Safety issues ☐ Eating Disorder ☐ Detox/withdrawal symptoms ☐ Substance Use ☐ Psychosis ☐ Mania ☐ Depression

☐ Other _____

Why does this patient require this higher level of care at this time? (Please provide frequency, intensity, duration of impairing behaviors and symptoms):

Medication adjustments (medication name and dose) during level of care:

Barriers to Compliance or Adherence: _____

Prior Treatment in past 6 months:

☐ Mental Health ☐ Substance Use Disorder ☐ Inpatient ☐ Residential ☐ Partial ☐ Intensive Outpatient ☐ Outpatient

Relevant Medical issues *(if any):*

Support System/Home Environment:

Treatment Plan (include objectives, goals and interventions):

If Concurrent Review — What progress has been made since the last review:

Why does member continue to need level of care?

Discharge Plan (including anticipated discharge date):

Complete the following if substance use is present for higher level of care requests:

Type of substance use disorder _____

Onset: ☐ Recent ☐ Past 12 Months ☐ More than 12 months ago

Frequency: ☐ Daily ☐ Few Times Per Week ☐ Few Times Per Month ☐ Binge Pattern

Last Used: ☐ Past Week ☐ Past Month ☐ Past 3 Months ☐ Past Year ☐ More than one year ago

Consequences of relapse: ☐ Medical ☐ Social ☐ Housing ☐ Work/School ☐ Legal ☐ Other _____

Urine Drug Screen: ☐ Yes ☐ No Vital Signs: _____

Current Withdrawal Score: (CIWA _____ COWS _____) or Symptoms (☐ check if not applicable) _____

History of: ☐ Seizures ☐ DT's ☐ Blackouts ☐ Other ☐ Not Applicable

Complete the following if the request is related to the treatment of an eating disorder for higher level of care requests:

Height: _____ Weight: _____ % of NBW _____

Highest weight: _____ Lowest weight: _____ Weight change over time (e.g. lbs lost in 1 month): _____

If purging, type and frequency: _____ Potassium: _____ Sodium: _____ Vital signs: _____

Abnormal EKG: _____ Medical Evaluation ☐ Yes ☐ No

Please identify current symptoms, behaviors and diagnosis of any Eating Disorder issues:

Please include any current medical/physiological pathologic manifestations:

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