State of Maryland

Uniform Treatment Plan Form

(For Purposes of Treatment Authorization)

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 NAME, ADDRESS & PHONE

Date Patient First Seen For This Episode Of Treatment ___/___/___

Have you communicated with the PCP/other relevant health care practitioners about treatment? O Yes O No

DSM-IV MULTIAXIAL DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)

AXIS I Dx Code ___.___ Dx Code ___.___

AXIS II Dx Code ___.___

AXIS III Does the patient have a current general medical condition that is potentially relevant to the understanding or management of the condition(s) noted in Axis I or II? O No O Yes

AXIS IV Severity of current psychosocial stressors

O None O Mild O Moderate O Severe

AXIS V: GAF Score Highest Past Year ___ At first Session ___ Current ___

Current Medications (if not applicable, no response is required)

O Anti-psychotic O Anti-anxiety O Anti-depressant O Psycho-stimulant O Injectables

O Hypnotic O Non-psychotropic O Mood stabilizer/Anti-convulsant O Other

Symptoms

Please rate the patient's current status on these symptoms, if applicable. **If not applicable, no response is required.**

	Ideation	Plan	Prior Attempt	None		Present	Absent
Suicidal ideation	O	O	O	O	Self-injurious behavior	O	O
Homicidal ideation	O	O	O	O	Substance use problems	O	O

Authorization Request Details

CPT Code ___ Number of Units ___

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: ___/___/___

Complete this section only if a second CPT is needed.

CPT Code ___ Number of Units ___

Frequency (once a week, etc.):_____

Requested Start Date of Authorization: ___/___/___

Signature of practitioner: _____ ___/___/___ Date

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