

Behavioral Health Partners Treatment Plan

BJC HealthCare _____ New Patient _____ Renewal

Patient Information (from patient insurance card)

Patient Name: _____

Date of Birth: ____/____/____ Health Plan Member ID #: _____

Provider Information

Clinician: _____ Credentials: _____

Clinician Phone: _____ Clinician Fax: _____

Service Requested

Next Appointment Date: ____/____/____ Frequency of Visits: _____X/week, or month, or year (Circle one)

Dates of service This Year: 01/01/____through 12/31/____ (_____)

Requested Units/CPT Code(s): _____90801 _____90805 _____90806 _____90862 _____90847 _____ other

***** Psychological Testing – Fill out Psychological Testing Request Form.

*****ECT – Call UM – 314-729-4007

Clinical Information (please enter DSM IV Numerical Codes)

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

GAF: ____/____

Current symptoms/status:

Relevant treatment data (including current medications):

Provider Signature: _____ Date: ____/____/____

To be completed by BHP staff only

Client Sees Another Provider: ____ Yes ____ No Total #of visits approved this year: ____/20(includes this auth)

Dates From: ____/____/____to ____/____/____ Number of visits approved: _____ CPT Codes: _____

Authorization Signature: _____ Date: ____/____/____